An Analysis and Evaluation of Certificate of Need Regulation in Maryland

Working Paper: Child and Adolescent Inpatient Psychiatric and RTC Services

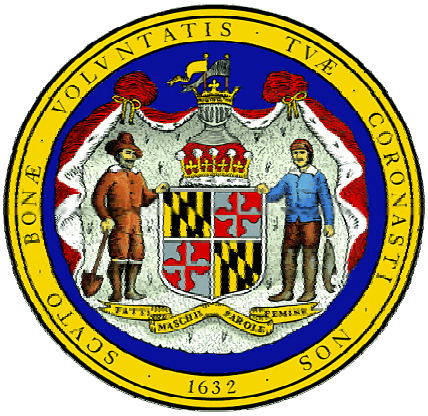

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Table of Contents

Table of Contents

Table of Contents

I. INTRODUCTION

A. Purpose of the Working Paper

Through House Bill 995[1], Maryland's General Assembly has required that the Maryland Health Care Commission ("MHCC" or the "Commission") examine the major policy issues of the Certificate of Need ("CON") review process. On January 1, 2000, the Commission submitted a report to the State legislature providing a detailed work plan for examining the CON process in Maryland.[2] The CON study work plan submitted to the General Assembly set out specific services for in-depth study over a two-year period, 2000-2001. In calendar year 2000, the Commission analyzed and evaluated Certificate of Need regulation in Maryland for the following health care services: acute inpatient obstetric services, cardiac surgery and therapeutic catheterization services, home health services, hospice services, and nursing home services. A final report providing the Commission's recommendations on these services was submitted to the General Assembly in January 2001.[3]

This working paper is one in a series of working papers that the MHCC is releasing in Phase II of its two-year study examining specific issues and implications for change to the CON model of regulation. The purpose of this report is to examine current CON policy and regulatory issues affecting inpatient child and adolescent psychiatric and Residential Treatment Center ("RTC") services in Maryland, and to outline several alternative options for change to the Certificate of Need program and their potential implications. Inpatient child and adolescent psychiatric and RTC services are types of services defined in health planning statute (Health-General Article §19-120 (a) that require a Certificate of Need to establish, and in some cases, to expand.

B. Invitation for Public Comment

The Commission invites all interested organizations and individuals to submit comments on the options presented in this working paper. Written comments should be submitted no later than the close of business Monday, November 19, 2001 to:

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[1] Chapter 702, Acts of 1999

[2] Maryland Health Care Commission, *Reports Required Under Section 11 of House Bill 995 (1999)-Health Care Regulatory Reform-Commission Consolidation, Part II*, Work Plan for Examining the Certificate of Need Process: Preliminary Report, January 1, 2000.

[3] Maryland Health Care Commission, *An Analysis and Evaluation of Certificate of Need Regulation in Maryland: Phase I Final Report to the Maryland General Assembly*, January 1, 2001.

C. Organization of the Working Paper

This working paper is organized into six major sections. Following this introduction, Part II contains an overview of child and adolescent inpatient psychiatric services and RTC services in Maryland with an inventory of existing providers, data on utilization trends and background information on, the impact of managed care and other reimbursement issues. Part III describes the functions of the State government agencies with regard to inpatient child and adolescent psychiatric and RTC services. Part IV of the paper describes what other states reported about how they regulate these services. Part V outlines alternative regulatory strategies for the State – maintaining, changing, or discontinuing the Certificate of Need review process for these services – that reflect different assumptions about the role and the ability of government, and of the health care system, to rationally allocate a crucial service in the public interest. Finally, summary tables, illustrating the alternative options to CON regulation for these two services discussed in this working paper are provided in Part VI Appendices. The Appendices provide statistical data on child and adolescent psychiatric services and maps showing the location of Maryland psychiatric facilities and RTCs.

II. OVERVIEW: INPATIENT CHILD AND ADOLESCENT PSYCHIATRIC SERVICES AND RESIDENTIAL TREATMENT CENTERS

A. Definition of Child and Adolescent Acute Psychiatric Care

Child and adolescent acute psychiatric care addresses disabling symptoms, including impaired reality, disordered or bizarre behavior, psychosis, depression, anxiety, hysteria, phobias, compulsion, insomnia, and eating disorders. This excludes primary diagnoses of alcohol and drug abuse, mental retardation, and organic brain syndrome. The State Health Plan defines children as ages 0-11 years and adolescents as ages 12-17 years. Due to the variability of psychiatric conditions, some children may be treated in a pediatric or adolescent unit, and some adolescents may be appropriately treated in either a child or adult unit consistent with their psychiatric diagnosis. For the majority of children and adolescents, quality of care is enhanced for when they are treated in separate units. Children and adolescents have different therapeutic needs from adults, and also require specialized educational and recreational programs. Because the length of stay for children and adolescents tends to be longer than that of adults, it is particularly important that they each be served in a discrete unit designed to meet their special needs[4].

B. Definition of Residential Treatment Centers

Residential Treatment Center ("RTC") means a "related institution" as defined in Health-General Article §19-301 *et seq.*, Annotated Code of Maryland and licensed under COMAR 10.07.04, that provides campus-based intensive and extensive evaluation and treatment of children and adolescents with severe and chronic emotional disturbance or mental illness who require a self-contained therapeutic, educational, and recreational program in a residential program in a residential setting whose average length of stay averages between 12 and 18 months. RTCs typically also offer outpatient day treatment services and schooling for children and adolescents who are unable to live at home.[5] Residential Treatment Centers focus on maximizing a child or adolescent's development of appropriate living skills. An RTC is a very intense level of care and should only be provided when therapeutic services available in the community are insufficient to address the child or adolescent's needs. Discharge planning is considered prior to placement in an RTC, and plans are actively reviewed throughout the treatment process[6].

C. Supply and Distribution of Services

Inpatient child and adolescent psychiatric services are provided in acute general hospitals, private psychiatric hospitals, and State psychiatric hospitals. Over the last five years, two private

[4] State Health Plan, COMAR 10.24.07, Supp. 14, AP-2, Revised June 30, 1997.
[5] Ibid.
[6] Ibid.

psychiatric hospitals, Gundry-Glass Hospital and Chestnut Lodge[7], that provided inpatient psychiatric hospital care for children and adolescents, have closed. Gundry-Glass Hospital located in Baltimore City, closed on October 14, 1997. Chestnut Lodge, located in Montgomery County, closed on April 27, 2001. (See the Maps in Appendices A-B of this paper.)

There are 235 child and adolescent inpatient psychiatric beds operating in the State of Maryland. As Table 1 and the Map Appendix A show, child and adolescent psychiatric beds may be found in all regions of the State, except for Southern Maryland.

Table 1
Child and Adolescent Psychiatric Hospital Facilities: Maryland, October 2001

Hospital	Jurisdiction	Beds(*)	Hospital Type
Finan Center	Allegany	18	State Psychiatric
Brook Lane Psychiatric Center	Washington	28	Private Psychiatric
Springfield	Carroll	18	State Psychiatric
Carroll County General	Carroll	12	Acute General
Sheppard Pratt	Baltimore	56	Private Psychiatric
Franklin Square	Baltimore	6	Acute General
Johns Hopkins	Baltimore City	15	Acute General
University of Maryland	Baltimore City	12	Acute General
Taylor Manor	Howard	20	Private Psychiatric
Potomac Ridge	Montgomery	25	Private Psychiatric
Laurel Regional	Prince George's	5	Acute General
Dorchester General	Dorchester	5	Acute General
Chesapeake Treatment Center.	Dorchester	15	Private Psychiatric
Total		**235**	

(*) Beds include licensed, operating, or other beds that have been approved by the Commission.

Source: Maryland Health Care Commission files and Office of Health Care Quality Licensure Reports, October 2001

In addition, there are seven acute general hospitals that treat a significant number of adolescents in their adult psychiatric units, but have not identified on their license any of their general hospital beds as serving an adolescent population. These hospitals treated 689 adolescents in calendar year 2000. The reasons for these increased admissions include: increasing referrals from emergency rooms and Department of Juvenile Justice facilities, closure

[7] Sheppard Pratt Health Systems purchased the inpatient beds from both of these facilities. Sheppard Pratt has relinquished the 37 child and adolescent psychiatric beds from Gundry - Glass Hospital, and is presently in discussions with Montgomery County officials regarding the relocation of the 30 child and adolescent psychiatric beds from the now closed Chestnut Lodge to another site within Montgomery County.

of private psychiatric hospitals and day treatment programs, and increasingly restrictive utilization decisions by Maryland Health Partners[8] [a subsidiary of Magellan Behavioral Health], for outpatient rehabilitation and other services for the "gray area" population.[9] These hospitals and their utilization are noted in Table 2.

Table 2
Acute General Hospitals Providing Adolescent Psychiatric Care in Adult Psychiatric Beds: Maryland, Calendar Year 2000

Facility Name	Jurisdiction	CY 2000 Child/Adol Discharges[10]	CY 2000 Adult Discharges	Pct. Child/Adol.	Licensed Adult Beds
Calvert Memorial	Calvert[11]	110	355	23.66	13
Suburban	Montgomery[12]	77	789	8.89	24
Montgomery General	Montgomery[13]	91	991	8.41	27
Washington Adventist	Montgomery	113	1453	7.22	40
Southern Maryland	Prince George's[14]	105	811	11.46	25
St. Joseph's	Baltimore	94	483	16.29	34
Howard Co. General	Howard	99	466	17.52	14
Total		689	5348	11.41	177

Source: Maryland Health Care Commission, October 2001

Residential Treatment Centers

There are 765 Residential Treatment Center beds for children and adolescents throughout the State as shown in Table 3 and Map Appendix B.[15]

[8] This is the Administrative Service Organization ("ASO") that holds the contract to administer Maryland's mental health carve out for the Maryland Medicaid and gray area populations.
[9] "Gray Area" population is defined as earning up to 300% of the Consumer Poverty Index ("CPI"). Services to this population will be reduced in the up-coming fiscal year due to the existing and projected budget deficit for the Maryland Mental Hygiene Administration and the mental health "carve-out".
[10] Based on 70 or more discharges.
[11] The facility has a psychiatric daycare licensed for adolescents and adults. There are also increasing referrals from Anne Arundel County.
[12] Increased referrals are coming from the emergency room. Closure of Chestnut Lodge day treatment decreased support of outpatient rehabilitation for the gray-area population.
[13] Increased referrals are coming from the emergency room. Closure of Chestnut Lodge will continue this trend.
[14] Increased referrals from the Department of Juvenile Justice's Cheltenham Unit is the cause for increased adolescent admissions.
[15] In a one day snapshot census, as of October 15, 2000, [the latest data available, not annualized], 24 children and adolescents were receiving residential treatment in out-of-state facilities, according to the State Coordinating Council.

Table 3
Maryland Residential Treatment Centers
October 2001

Facility Name	Jurisdiction	Number of Beds
Edgemeade at Focus Point	Anne Arundel	26
Regional Institute for Children/Adolescents-Baltimore	Baltimore City	45
Woodbourne Center Inc.	Baltimore City	54
Good Shepherd Center	Baltimore City	105
Berkeley & Eleanor Mann Residential Treatment Center	Baltimore	17
Villa Maria	Baltimore	95
Chesapeake Youth Center	Dorchester	49
The Jefferson School	Frederick	50
Adventist Behavioral Health System of Maryland	Montgomery	83
Taylor Manor Residential Treatment Center	Howard	17
Regional Institute for Children/Adolescents-Rockville	Montgomery	80
Edgemeade at Upper Marlboro	Prince George's	61
Regional Institute for Children/Adolescents-Southern Maryland	Prince George's	40
Chesapeake Treatment Center at The Hickey School	Baltimore	26
Total		748

Source: Maryland Health Care Commission Data; Office of Health Care Quality, DHMH Licensure Reports, October 2001

However, only one RTC, Villa Maria Residential Treatment Center in Baltimore County, serves children. The RTCs are further subdivided by the following types of population they serve:

- "Lisa L" population[16] – refers to facilities serving those at risk for over staying in inpatient facilities, including hospitals and respite care,
- Seriously emotionally disturbed delinquent youth ("SEDDY") population – refers to facilities serving those adjudicated by the court and committed to the Maryland Department of Juvenile Justice,

[16] "Lisa L" case is a federal class action lawsuit brought in 1987 against the Maryland Department of Health and Mental Hygiene (DHMH), Department of Human Resources (DHR) and Department of Juvenile Justice, (formally the Department of Juvenile Services) (DJS) on behalf of all children and adolescents who are held in Maryland's State psychiatric and private psychiatric hospitals after the time they are ready for discharge, as determined by the hospital treatment team, or who are discharged to placements in which they do not receive the services recommended by the hospital staff. An Interim Settlement Agreement, which required the State to implement discharge plans within decreasing timelines, went into effect in May 1990.

- Sex offender population – refers to facilities serving those committed by the courts to the Maryland Department of Juvenile Justice with a principal offense of sex offender,

- Generic RTC – refer to facilities that serve a broad spectrum of youth who are seriously emotionally disturbed and mentally ill.

The Commission has adopted a State Health Plan chapter that addresses the sex offender and "Lisa L" population at COMAR 10.24.01.07 F. and G., respectively[17].

There are other special populations that have been identified as needing separate and distinct RTC units and other resources to meet the needs of particular children and adolescents[18]. These include children and adolescents with co-occurring disorders of mental illness and mental retardation, and adjudicated youth who require a higher level of care than that currently provided in the units for seriously emotionally disturbed delinquent youth ("SEDDY").

Respite Care

The respite level of care provides rehabilitation support and active treatment for children and adolescents[19]. Respite care is more like long-term psychiatric hospitalization as opposed to a brief stay to spell other caregivers. There are five separate and distinct respite care units in three facilities that serve children and adolescents. The three respite care facilities are located at Sheppard Pratt in Baltimore County, Brook Lane Psychiatric Center in Washington County, and Taylor Manor in Howard County. The Sheppard Pratt facility has two units, one each for children and adolescents, with a total of 26 beds. Brook Lane Psychiatric Center's unit is called Stonebridge, and serves youth between the ages of 11 and 14. Taylor Manor has two units, one a low intensity unit, and one a high intensity unit. At any given time, over 60 youth are awaiting RTC placement in these respite care facilities. About half of these youth remain in treatment in respite care for over 90 days. While the Commission does not regulate respite care, it is an integral part of the full continuum of care, and directly affects the availability of RTC and hospital care services.

D. Hospital and Residential Treatment Center Trends

Commission Staff's review of a breakdown of child, adolescent, and adult psychiatric discharges in acute general, private psychiatric, and state psychiatric hospitals for calendar years 1996-2000 can be found in Appendices I-X.[20]

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[17] The SHP identifies 12 additional RTC beds for the "Lisa L" population to be approved and implemented only if needed. The Subcabinet has recommended to the Commission that these beds be held in abeyance until data are collected to support the need for these beds. Additionally, the SHP at COMAR 10.24.01.07 identifies 26 RTC beds specifically dedicated to serving adjudicated adolescent sex offenders. As of this writing, the Commission has not granted a Certificate of Need for this special population.

[18] *Report of the Out-of-State Placement Workgroup: Resources for Maryland Youth in Out-of-State Institutional Placements*, Maryland Health Resources Planning Commission, March 20, 1998

[19] COMAR 10.21.27

[20] Source: Maryland Hospital Discharge Abstract, CY 1996-CY 2000[for general and private hospital data], and Maryland Health Management Information System, CY 1996-CY 2000 [for State psychiatric hospital data].

Acute General Hospital Trends

For children ages 0-11 years, in CY 1996 there were 527 discharges from general hospitals. In CY 2000, there were 740 discharges for this age group, an increase of 40 percent. For the adolescent age cohort during this same time period, there were 1,414 discharges in CY 1996 and 1,557 discharges in CY 2000, an increase of 10 percent. Between CY 1996 and CY 2000, the average length of stay for children decreased 28.7 percent from 12.6 to 8.99 days. The average length of stay for adolescents in the same time period decreased by 16.1 percent from 7.51 to 6.3 days.

A separate review (See Appendices I and II) also revealed that three acute general hospitals in Central Maryland treated 95 percent (773/813) of inpatient child psychiatric patients. These hospitals are Johns Hopkins Hospital, University of Maryland Hospital, and Franklin Square Health System.

For adolescents aged 13-17 years, there has been a 9.8 percent increase in the number of discharges (1,262/1,342) over the same years. A broader range of hospitals in the State treat adolescents, and as demonstrated by Table 2, there are seven additional hospitals with adult psychiatric units that also treat a substantial number of adolescents in those psychiatric units.

State Hospital Trends

The Mental Hygiene Administration, within the Department of Health and Mental Hygiene, is responsible for operating two 18-bed adolescent units, one at Crownsville State Hospital in Anne Arundel County and the other at the Finan Center in Allegany County.[21] Between CY 1996 and CY 1999, adolescent discharges from State psychiatric hospitals decreased by 22.47 percent from 227 in CY 1996 to 176 in CY 2000. Patient days decreased significantly at these two facilities between 1996-2000 – from 6,784 to 5,438 (a decline of 19.8 percent). The average length of stay remained fairly stable over this time period. Adolescents were hospitalized an average of 29.9 days in 1996 compared to 30.9 days in 2000.[22]

Private Psychiatric Hospital Trends

The number of child discharges from private psychiatric hospitals has increased 18.3 percent from CY 1996 to CY 2000 -- from 531 to 628. The number of adolescent discharges has decreased during this same period by 9.3 percent from -- 2,364 to 2,143. The average length of stay for children in private psychiatric hospitals has decreased in the period CY 1996-CY 2000 from 16.63 to 14.58 days, a decrease of 12.3 percent. However, during this same period, adolescents discharged from private psychiatric hospitals showed a more significant decrease in average length of stay, from 24.31 to 8.61 days, a decrease of 64.6 percent. Total charges for the

[21] The State of Maryland does not operate a hospital-based facility for children ages 0-11; however, a few children are treated briefly at state hospitals. Between CY 1996 and CY 2000, no more than ten children, ages 0-11, were treated in State hospitals. Source: Mental Hygiene Administration, Data and Analysis Unit, October 16, 2001.
[22] Source: Mental Hygiene Administration, Data and Analysis Unit, October 16, 2001

combined age groups fell precipitously from $44,624,874 to $19,889,109, a drop of $ 24,735,765 [in current dollars], or 55.4 percent.

Cumulative Hospital Trends

Appendix VI provides separate child and adolescent utilization trends by age and year for discharges, patient days, total charges, average length of stay, average charge, and per diem for acute general and private psychiatric hospitals. For the 0-11 year age cohort, there has been a 29 percent increase, from 1,058 to1,368, in the number of inpatient child psychiatric discharges for the time period CY 1996- CY 2000. During the same five years, for the 12-17 year age cohort, there has been a 2 percent decrease in the number of adolescent discharges from 3,778 to 3,700; however, during the intervening years there have been fluctuations in the number of adolescent discharges. (See Appendix X). For example, between CY 1999 and CY 2000, the combined number of child and adolescent psychiatric inpatient discharges decreased by 15 percent, from 5,957 to 5,080. It is unclear whether or not there has been a corresponding increase in the number of community-based services for children and adolescents.

For children, the average length of stay has experienced a significant decrease from 14.62 days in CY 1996 to 11.56 days in CY 2000,(a decrease of 21 percent). The average length of inpatient stay for adolescents from CY 1996-CY 2000 decreased 57.6 percent, from 18.02 to 7.64 days. The overall length of stay for the combined age group dropped almost 50 percent from 17.28 to 8.70 days. Similarly, total charges for the combined age groups dropped from $57,909,793 to $33,454,776, a decrease of $24,000,000 [in current dollars], or 42 percent.

Residential Treatment Center Trends

A key to analyzing RTC issues is to understand that each RTC is a unique facility. Each of the 14 RTCs in Maryland is a unique facility with different influences that affect the utilization, financing, and management of the facility. These influences include the following:

- the populations served (age, sex, “Lisa L”, seriously emotionally disturbed delinquent youth, violent juvenile sex offenders)
- geographic regions;
- each facility’s corporate structure (i.e., non-profit, for profit, or State – run, owned, and operated);
- funding streams (i.e., Medicaid, State general funds, education funds, county jurisdictional funding, philanthropic funds);
- the entity controlling admissions (the court systems, Department of Juvenile Justice; the Multi-Agency Review Team; the State-contracted Administrative Service Organization, Maryland Health Partners; each facility’s admission criteria); and
- the availability of appropriate community-based services.

With all of these variables continually in flux, different and conflicting trends emerge. Commission Staff contacted several RTCs in the State, inquired about their utilization and current trends, and learned that some RTCs are experiencing a significant number of empty beds

for the first time in several years, while other RTCs are experiencing full occupancies with waiting lists, including the respite programs. [23] Those facilities experiencing reduced utilization mention several factors influencing their current downward trend in occupancy. There have been marked decreases in the number of admissions from child serving agencies to these facilities. Part of the overall decrease may be due to direct instruction to the State-operated Residential Institutes for Children and Adolescents ("RICAs") from the State Mental Hygiene Administration to reduce lengths of stay to nine months. One RICA has taken this a step further, and is seeking to discharge patients as soon as they begin to improve, which often results in a reduced length of stay. Some RICAs are not staff to their license RTC capacity.

Some RTCs note that the new seclusion and restraint rules promulgated by the federal Centers for Medicare and Medicaid ("CMS")[24], formerly the Health Care Financing Administration, have added direct and indirect costs to the treatment of children and adolescents. Therefore, children and adolescents needing this type of care are either not admitted, or are discharged from the RTC to another type of facility. However, other RTCs have formulated inventive strategies to contend with the staffing coverage issues, funding, and sharing of resources that result from the implementation of this rule.

Some stakeholders note increasing problems connected with obtaining the required documentation along with patient medical and educational evaluations from some jurisdictional social services organizations. The attempts to obtain this documentation often require inordinate amounts of professional staff time, and its absence precludes the admission of the patient. Some facilities that have surmounted the referral and paperwork issues are still backed up with patients seeking admission. These facilities are ones whose admissions are controlled by DJJ or the Multi-Agency Review Team ("MART").

Others contend that school districts in the state are responding to a financial disincentive to place children and adolescents into RTCs, and that is the cause of the downturn in admissions to some RTCs. Some school districts will not refer students to RTCs because they have to pay increased education and therapeutic costs. The inclusion model developed by these districts has, in fact, reduced the flow of referrals to RTCs.

Another factor affecting utilization of RTCs is the closure, or the potential closure, of child and adolescent outpatient/day treatment programs. Without these community-based services, these outpatients may very well decompensate and require RTC placement, or the inpatient facilities will become the only places to provide the required services. At least eight outpatient/day treatment sites for children and adolescents have closed due to lack of profitability. [25] Lack of profitability here, and in RTCs, is linked to the State or Administrative Service Organization-mandated reimbursement policies that have created financial hardships, and may lead to further closures. These reimbursement policies include the following: failure to

[23] Telephone contacts with RTCs by Paul Gentile of Commission Staff, October 11, 2001.

[24] Medicaid Program; Use of Restraint and Seclusion in Psychiatric Residential Treatment Facilities Providing Psychiatric Services to Individuals under Age 21; Final Rule 42CFR Parts 441 and 483, January 22, 2001

[25] These closures include VESTA, Prince George's County; Affiliated Sante, Charles County; Edgemeade, Charles County; Woodbourne, Baltimore City; Prince George's County Health Department; Granite House, part of the Sheppard Pratt Health System, at both St. Agnes Hospital in Baltimore City and Stoneridge in Randallstown, Baltimore County.

make timely payments [some RTCs are facing deficits of $2 million or more]; retrospective utilization reviews that deduct funds from previously ASO-approved services; and a system structured such that an RTC provider cannot be reimbursed before a patient is resident for at least six weeks. This has a definite financial impact on the cash flow of the facility.

The impact of these measures is that all RTCs are serving a patient population with more severe conduct disorders, lower I.Q.s, more chronic sex offenders, co-morbid conditions (mental illness, substance abuse, mental retardation, and other medical conditions), and more persistent mental illness.

A serious problem in this area is that there is no reliable database that collects and aggregates RTC information into one single source; consequently, trend information for the RTC population in Maryland is not obtainable.

Some organizations do maintain fragmented and partial data sets. For example, the Mental Hygiene Administration, in its management information system, does collect data for the Residential Institutes for Children and Adolescents in Rockville, Southern Maryland, and Baltimore. The Maryland Health Partners data collection system, known as the Crystal System, collects data based upon claims and authorizations. Since the State of Maryland contracts with Maryland Health Partners only to pay for Medicaid recipients who receive mental health treatment, these claims data are missing patient days that are not reimbursed by Medicaid. Specific information from Maryland Health Partners regarding RTC utilization is not readily available to public agencies, and has only recently become available to the Mental Hygiene Administration on a limited basis. The limited data produced by the Crystal System indicate that from July 1, 1997 through September 27, 2001 there were 2,152 discharges from all RTCs in Maryland. Of the 2,152 discharges:

- 15.1 percent (324) were for stays at an RTC of less than 90 days;
- 14.5 percent (313) were for stays from 91-180 days;
- 35.6 percent (766) were for stays from 181-365 days;
- 22.0 percent were for stays from 366-1½ years (473/2,152 days); and
- 12.8 percent (276 days) of the discharges were for more than a year and a half. (Source: See Appendix XI)

Out-of-State Trends

Maryland children and adolescent have received treatment in three out-of-state Residential Treatment Centers. These facilities are: Devereux in Florida, Devereux in Georgia, and The Pines in Virginia. There have been 27, 19, and 26 children and adolescents served in these RTCs in FY 1999, FY 2000, and FY 2001, respectively. With the goal of reducing out-of-state placement, these figures represent a significant reduction in out-of-state RTC placements compared to previous years, and indicate progress toward the legislatively–mandated goal of minimizing the number of Maryland children sent out-of-state for RTC care.[26]

[26] Telephone contact with Jean Clarren, State Coordinating Council, Office of Children , Youth, and Families, Oct. 16, 2001

E. Issues Affecting the Utilization of Child and Adolescent Mental Health Services

1. Increased prevalence

According to the Report of the United States Surgeon General, 20 percent of U.S. children and adolescents (15 million), ages 9-17, have diagnosable psychiatric disorders. Further, the Center for Mental Health Services estimated that 9 to 13 percent of U.S. children and adolescents, ages 9 to 17, meet the definition of "serious emotional disturbance" and 5 to 9 percent of U.S. children and adolescents, "extreme functional impairment[27]." National data indicate that only about 20 percent of emotionally disturbed children and adolescents receive some kind of mental health services, and only a small fraction of them receive evaluation and treatment by child and adolescent psychiatrists[28]. Moreover, the demand for services of child and adolescent psychiatry is projected to increase by 100 percent by 2020 (U.S. Bureau of Health Professionals, Department of Health and Human Services, 2000). Moreover, the population of children and adolescents under age 18 is projected to grow by more than 40 percent in the next 50 years from the current 70 million to more than 100 million by 2050 (U.S. Bureau of the Census, 1999). Recent evidence compiled by the World Health Organization indicates that by the Year 2020, childhood neuropsychiatric disorders will rise proportionally by over 50%, internationally, to become one of the five most common causes of morbidity, mortality, and disability among children[29].

Compounding the problem is that, according to the American Medical Association (1999) and the U.S. Bureau of Health Professionals (2000), there are currently only about 6,300 fully trained child and adolescent psychiatrists practicing in the U.S. Given these barriers that prevent children, teenagers, and their parents from seeking help from the small number of specially trained professionals, this places an increased burden on pediatricians, family physicians, and other gatekeepers to identify children for referral and treatment decisions.[30]

2. Impact of Managed Care

With the advent of Maryland's Medicaid carve-out in 1998[31], it was anticipated that admissions of children and adolescents to inpatient psychiatric facilities would be restricted and

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[27] Department of Health and Human Services, *Report of the Surgeon General's Conference on Children's Mental Health: A National Agenda, December 1999*

[28] American Academy of Child and Adolescent Psychiatry Work Force Fact Sheet, www.aacp.org/training/workforce.htm

[29] Department of Health and Human Services, *Report of the Surgeon General's Conference on Children's Mental Health: A National Agenda*, December 1999

[30] American Academy of Child and Adolescent Psychiatry Work Force Fact Sheet, www.aacp.org/training/workforce.htm

[31] In the past, public mental health services in Maryland were organized around two separate funding sources through the Department of Health and Mental Hygiene (DHMH): Medicaid (Medical Assistance) and Mental Hygiene Administration (MHA) grant funding. These two funding sources for public mental health services have been merged, creating a mental health "carve-out" from the State's Medicaid funds. These funds are transferred to the Mental Hygiene Administration that is responsible for the Public Mental Health System in Maryland.

lengths of stay would be curtailed. It was also anticipated that the Department of Health and Mental Hygiene's Mental Health Administration ("MHA") would receive a 1915c Medicaid Waiver that would encourage alternatives to inpatient care. However, as Appendices I-XII demonstrate, while inpatient hospital admissions to have decreased, the lengths of stay in RTCs, have increased since the imposition of the Maryland Medicaid carve-out. Despite the increase in utilization and capacity of RTCs, there is anecdotal evidence that children and adolescents are not receiving the appropriate inpatient services as evidenced by long stays in hospital emergency rooms before these individuals are either admitted, referred to another service, or retuned home.

3. Reimbursement Issues

The Administrative Service Organization ("ASO"), Maryland Health Partners, utilizing stringent utilization review criteria linked to its capitation rates from the Medicaid Carve-Out, has strongly encouraged shorter lengths of stay in hospitals, resulting in higher recidivism rates for mentally ill children and adolescents inpatient hospitals.

Comments received on the CON Working Paper: *An Analysis and Evaluation of Certificate of Need Regulation in Maryland: Inpatient Psychiatric Services* support this view. Dr. Michael. Kaminsky, M.D., Clinical Director and Associate Professor, Johns Hopkins University, Department of Psychiatry and Behavioral Sciences, states that,

> "in psychiatry, in particular, the HSCRC rate methodology has incentivized not only short stay, but also an active avoidance on the part of general hospitals for taking care of the most difficult cases. The HSCRC argues that its cost per case methodology, which includes case-mix intensity and severity adjustments, does not, in fact, incentivize taking care of the easiest cases.
>
> In actual fact, the HSCRC methodologies are too obscure and arcane for psychiatric patients to function in the way intended. When a patient presents [with] a surgical condition, it is generally easy for a physician to know what resources are going to be necessary in the patient's care and can respond to case-mix intensity adjustments. In psychiatry, for all but the most straight-forward cases, those resource-utilization predictions cannot be made. As a result, any psychiatric patient with a significant co-morbidity, is diverted from general psychiatric units, typically to a state hospital or private hospitalization just because of an overt need for a longer length of stay. As a result, we are treated to the spectacle of the general hospital psychiatric unit trying to fill a sieve and worrying where to get a sufficient volume of easy cases while medically complicated or [more] difficult psychiatric patients are transferred to State and private psychiatric hospitals. From there, when their medical conditions require it, they are transferred back to the general hospital's medical units and so, ping-pong back and forth".[32]

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[32] Michael J. Kaminsky, M.D., letter to Barbara G. McLean, Interim Executive Director, Maryland Health Care Commission, August 13, 2001

The Commission along with the Health Services Costs Review Commission, Mental Hygiene Administration, and Developmental Disabilities met with providers to better reflect the cost of treating one of the special populations – patients with co-existing diagnosis of psychiatric disorders with a developmental diagnosis. As a result of these meetings, there was a methodological change where patients will be reassigned from their usual Diagnostic Related Group (DRG) to a special DRG.[33] This will minimize the financial disincentive to hospitals to avoid these patients since these cases would be more expensive that the average case in their designated DRG.

With the five private psychiatric hospitals projecting losses of $7 million in 2001, and to prevent possible closure of facilities, the State of Maryland applied for and received a waiver from the federal Center for Medicaid and Medicare Services ("CMS") that will allow for a retroactive rate increase as of July 1, 2001 in the amount of $9 million in Medical Assistance funds. Private psychiatric hospitals will receive, on average, 84% of the Maryland Health Services Cost Review Commission's ("HSCRC's") approved rates compared with 94% of HSCRC's approved rates for acute general hospitals.

4. Systemic Factors

New RTC Beds

The State Health Plan bed need projections for "Lisa L" RTC beds and for violent juvenile sex offender beds have not been entirely awarded by the Commission. Specifically, twelve "Lisa L" beds have been held in abeyance by the Subcabinet, pending development of data to support additional need (See discussion below under Interagency Consensus Building). Twenty-six RTC beds for violent juvenile sex offenders have not been allocated. Therefore, at this writing, the future for the allocation of these beds and their impact upon the system is unclear.

Interagency Consensus Building

The Maryland Health Care Commission ("MHCC") recognized that a multi-agency approach is needed to gain a consensus among stakeholders throughout the State regarding the concerns facing RTCs. Therefore, it approached the Subcabinet to convene a workgroup in response to the State Health Plan requirement[34] that the Subcabinet supply the MHCC with periodic reports which would include a determination of continued need for the 24 "Lisa L" beds, a number expanded to 34 beds with the addition of 10 waiver beds [5 each to Sheppard Pratt Health System and Taylor Manor Hospital][35] plus 12 other "Lisa L" beds (beds that were held in abeyance pending the submission of these reports), along with the State's overall need for residential treatment center beds.

[33] DRG 534
[34] COMAR 10.24.07G.6(a).
[35] The MHCC granted five RTC waiver beds to Sheppard Pratt Health System on February 2, 2000 and Taylor Manor Hospital on February 17, 2000.

The workgroup recommended to the Commission:

- that the 34 "Lisa L" beds currently in use be continued, based on regular full occupancy of the beds and a waiting list for the beds;
- that these 34 beds be continued for two (2) years, and that the beds continue to be considered temporary (as designated by the SHP), with a re-evaluation of the need for these beds at the end of that time.
- That efforts continue to promote funding for use of community-based services for those children who can be served in placements that are less restrictive than the RTC level of care. Further, should additional RTC beds be opened in the future, some of these funds might be needed to provide the State funds to be matched with federal Medicaid dollars.
- that a decision about the use of the 12 additional beds be deferred until the larger, more complex issues listed above are addressed as the workgroup continues to meet beginning in January 2001[36].

Since these recommendations were released on December 12, 2000, the workgroup issued a Joint Chairmen's Report[37] in response to five questions which were posed by State legislators. This report identified serious problems with basic data collection. For example, questions posed by the legislators about the number of children awaiting RTC placement or the length of the wait for placement could not be answered. However, the Subcabinet indicated that it has three initiatives in process to address these types of important data requests.

The first of these initiatives is to re-start and improve the "Lisa L" database. The second is to release a Request for Proposal ("RFP") to conduct a statewide needs assessment of children and adolescent services, including RTCs, to be issued in the fall of 2001. The third is a proposal to develop two inter-related, human services database systems and a resource development directory, a contract for which is to be awarded November 1, 2001.

Other questions posed by the legislators dealt with educational issues. In response to these questions, the Maryland State Department of Education will conduct a telephone baseline survey to determine the status of the provision of education for disabled and non-disabled students in all in-state private RTC programs. The last question posed by the State legislators sought to resolve problems associated with RTC placement delays, including funding of alternate community placements. Special Secretary Bonnie A. Kirkland, of the Governor's Office of Children, Youth, and Families, has formed three workgroups (Finance Strategies, Connections, and Special Needs) to address inter-agency services to special needs children, including those children and adolescents in RTCs.

While the Commission Staff recognizes that the development of a consensus among Subcabinet agencies is a difficult and time-consuming process, Staff does note that the Subcabinet has committed that it will respond fully to the Legislature's questions by January 2, 2003.

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[36] Recommendations to the Maryland Health Care Commission from the Subcabinet Regarding Residential Treatment Center Bed Need, December 12, 2000

[37] Joint Chairmen's Report on Residential Treatment Center Bed Need, September 2001

5. Lack of Coordinated Data Base for Planning Purposes

The Residential Treatment Center Bed Need Workgroup discussed existing and potential data sources, other statewide initiatives undertaken by the Subcabinet as a whole, or by one or more of its member agencies. In July 2001, the co-chairs of this workgroup conducted a survey of the State child-serving agencies to determine the extent and adequacy of current agency data collection regarding RTC placements. The survey found that:

- Fragmentary and partial data are currently maintained separately by each child-serving state agency;
- Data are manually reported and aggregated, and not electronically stored;
- Data may be available from individual RTCs; however, the counts of children awaiting placement are not necessarily unduplicated, and the service status of the children is unknown.

In addition, there is a lack of integration of databases among the involved state agencies. There is no formal interconnect or transfer of information from inpatient psychiatric hospitals to RTCs to respite care or any community-based services. The lack of an up-to-date, integrated statewide database prevents the agencies that serve children from determining what children and adolescent psychiatric services are needed

6. Lack of Availability of Child and Adolescent Inpatient Care

Due to the closures of Gundry-Glass Hospital and Chestnut Lodge, two of the larger providers of child and adolescent psychiatric services in Maryland, today there are fewer options for individuals to access child and adolescent psychiatric inpatient services. For the remaining facilities that provide child and adolescent inpatient psychiatric services, this has resulted in a crisis situation.

As reported in the *Baltimore Sun*,[38] since 1995, the number of children treated at Johns Hopkins Pediatric Emergency Department for behavioral or emotional problems has nearly doubled to 730 a year. University of Maryland's Pediatric Emergency department is also swamped, so much so that it is considering opening a walk-in clinic for children and adolescents with psychiatric problems.

7. Lack of Specialty Programs in RTCs and Hospitals for any of the Following Populations: Mentally Ill/Developmentally Disabled; Seriously Emotionally Disturbed Children; Sex Offenders; Seriously Emotionally Disturbed Delinquent Youth

There has been no separate continuum of care developed to treat special populations. As a result, many of these children and adolescents are currently served in generic facilities that attempt to meet their needs.

[38]Diana K. Sugg, "A Hospital Crisis: Children in Need of Psychiatric Care," The Baltimore Sun, February 13, 2000

Co-Existing Disorders of Mental Illness and Developmental Disabilities

For those children and adolescents with co-existing mental illness and developmental disabilities, there is currently no specialized program in RTCs or hospitals.[39] [40] The staff from MHCC, the Maryland Health Services Cost Review Commission ("HSCRC"), the Mental Hygiene Administration ("MHA"), and the University of Maryland met to explore strategies to plan for this population in hospitals. As a result of these meetings, data relating to this population were factored out from the State's Medicare Waiver so that there would not be a disincentive for hospitals to treat the special needs of these patients who, with their longer lengths of stay, incur increased costs. Information from RTC providers and from the State Coordinating Council indicates that an increasing number of mentally ill/developmentally disabled children and adolescents are being served in out-of-state facilities as well as in-state facilities[41].

Seriously Emotionally Disturbed Children

In Maryland, there is only one RTC serving the needs of seriously emotionally disturbed children ages 5-11years, at Villa Maria Residential Treatment Center in Baltimore County. The absence of other RTCs serving this age cohort in other regions impedes family participation in family and other therapies, and makes the monitoring and coordination of local community-based services, including treatment, aftercare, education, and other social supports for the child and family more difficult.

For this population, there are five hospitals, of which only four are operating. The 30 beds bought by Sheppard Pratt Health System from Chestnut Lodge are not in operation. If they come back on-line, they must be located within Montgomery County, or Sheppard Pratt will need to apply for a separate CON to move these beds to another jurisdiction. As noted above, Southern Maryland has no child psychiatric hospital resources. The Maryland counties in the Washington Metropolitan Area must rely upon Children's National Medial Center in Washington, D.C. and Dominion Treatment Center in Virginia to provide inpatient child psychiatric services.

[39] Kennedy Krieger Institute has 20 Special Hospital-Pediatric beds for patients school aged through age 21who are diagnosed as severely mentally retarded and who exhibit behaviors that require hospitalization for up to six months. This population is different from one with a diagnosis of mentally illness co-existing with developmental disabilities.

[40] By January 2002, Sheppard Pratt Health System is planning to add 12 beds on its Towson campus for males and females, ages 10-18 years, diagnosed with the co-existing disorders of mental illness and developmental disabilities.

[41] According to Janice Furst, M.D., Sheppard Pratt Health System, and Jean Clarren, Executive Director, State Coordinating Council, psychological test results of children and adolescents admitted to Sheppard Pratt in the period of calendar year 1999-2000 revealed a 20 point drop in standardized I.Q. scores. Data from the State Coordinating Council indicate that several of the out-of-state placements are for children with mental illness and developmental disabilities.

RTC-Appropriate Violent Juvenile Sex Offenders

The State Health Plan defines RTC-Appropriate Violent Juvenile Sex Offenders as "the most violent, predatory, hard-core and aggressive juvenile sex offenders. These individuals may have serious co-existing mental and behavioral problems and could be multiple offenders. These individuals include serial pedophiles, rapists, and others who are deemed to be of imminent risk to the public safety, and therefore must be treated in Department of Juvenile Justice ("DJJ") admission-controlled facilities". Within the State Health Plan, COMAR 10.23.07 F, the admissions to the facilities projected in the plan are controlled by the Department of Juvenile Justice. One 26-bed facility has been approved at the Hickey School to treat violent juvenile sex offenders.[42] The State Health Plan identifies another 26-beds needed for this population. The State Coordinating Council reports that there are 17 sex offenders that have been placed in out-of-state RTC facilities. The Department of Juvenile Justice also reports that there are individuals in the juvenile justice detention and training schools who would be appropriate for RTC placement in a specific program for violent juvenile sex offenders.

The problem with the development of an RTC for the violent juvenile sex-offender population is selecting location of a site for the program. Several neighborhood groups and concerned citizens have objected to having this type of facility in their neighborhoods. By the time the Commission was finally able to approve the Hickey School facility it had to change its site three times during the long course of its CON review[43].

Seriously Emotionally Disturbed Delinquent Youth ("SEDDY")

The Seriously Emotionally Disturbed Delinquent Youth ("SEDDY") population is defined as a delinquent population adjudicated by the Maryland Department of Juvenile Justice, that has a serious Axis I, DSM –IV, or multiple mental health diagnoses. This population may also have a combination of the following problems:

- severe psycho-social stressors;
- special education needs (learning disabilities);
- school problems (truancy, suspension, expulsion or dropout);
- attention deficit and hyperactivity disorders (ADHD);
- physical/sexual;
- emotional abuse;
- drug abuse history;
- a history of multiple serious offenses along with family, community, and personal violence;

[42] It should be noted that both the RTCs at Adventist Fairbridge [formerly Charter Fairbridge], Montgomery County and Woodbourne in Baltimore City have dedicated beds for sex-offenders; however, these beds provide care to less acute patients, when compared to the acuity level of patients at the Hickey School RTC facility in Baltimore County.
[43] On July 13, 1999, MHRPC granted a CON to Chesapeake Treatment Centers, Inc., for the relocation of a previously approved 26-bed violent juvenile sex offender RTC to the Charles H. Hickey, Jr. School. Docket No. 88-02-1466 was originally approved July 8, 1997.

- aggressive behaviors necessitating placement in a 24-hour residential facility for 12-24 months for the containment, protection, and treatment for the patients, staff, and community; and
- has been in secure care, and has had previous stays at RTCs.

Currently, the State provides some level of treatment for this population at the Edgemeade at Focus Point facility on the grounds of Crownsville State Psychiatric Center in Anne Arundel County. However, according to DJJ, as Edgemeade is presently structured, it has the capacity for only a moderate level of security. The SEDDY population would require a higher level of treatment and security.

It was to address this higher level of need that on December 21, 1998, the Maryland Health Resources Planning Commission ("MHRPC"), predecessor to this Commission, received a letter from the Subcabinet for Children, Youth, and Families petitioning the Commission to amend the State Health Plan and expand, by 24, the number of RTC beds dedicated to seriously emotionally disturbed delinquent youth. Following receipt of this letter, which was also supported by a host of studies confirming the need for RTC beds for the SEDDY population,[44] the Commission received other letters of support from county governments, the offices of county states attorneys, the Office of Children, Youth, and Families, the Maryland State Department of Education, state legislators, and providers.

The Commission also received letters in opposition to this petition from the Ad Hoc Coalition and from the Maryland Juvenile Justice Coalition contending that there is sufficient in-state capacity for the SEDDY population. To date, there has been no resolution regarding the need for and location of a facility for the SEDDY population.

Interim Residential Treatment Center Capacity ("Lisa L") – COMAR 10.24.07G

The Interim Residential Treatment Center Capacity, otherwise known as "Lisa L," was adopted by the Maryland Health Resources Planning Commission on February 11, 1997. "Lisa L" was a class action lawsuit brought by the Maryland Disabilities Law Center on behalf of a class of child and adolescent patients who over-stayed in State and private psychiatric hospitals, and were not receiving appropriate care. In response to this lawsuit, the Commission, along with several stakeholders, promulgated a chapter of the State Health Plan (COMAR 10.24.07.G) that projected need for 24 additional RTC beds, with an added 12 RTC beds to be held in abeyance if data supported the need for additional capacity. The State Health Plan provided that no more

[44] These studies include: Goron et al, Wettstein, Robert M. (Editor), *Treatment of Offenders With Mental Disorders*,), 1998, Chapter 8, Treatment of the Juvenile Offender, p. 365 – 429;
Final Report of the Out-of-State Placement Workgroup, MHRPC (April 1998);
Shelton, Deborah, Ph.D., R.N., *Estimates of Emotional Disorder in Detained and Committed Youth in the Maryland Juvenile Justice System*, March 1998;
Forensic Steering Committee Report, Mental Hygiene Administration, June 1997;
Final Report of the Regional Institute for Children and Adolescents ("RICAs") Organizational Subcommittee, September 1993;
Student, David, M.D. and Myhill, John E., Ph.D., *Mental Health Needs at the Montrose and Hickey Schools: Models for Treatment* , 1986

than three RTC units for adolescents would be approved under this need projection, and these three units would only be located in special hospital psychiatric facilities which had excess capacity and were located in Central Maryland. The SHP also required that admission to these units be exclusively regulated by the Multi-Agency Review Team ("MART") comprised of the child-serving State agencies.[45]

The section above entitled "Interagency Consensus Building" discusses the "Lisa L" planning process, the Commission-selected "Lisa L "providers, and the recommendations of the RTC Workgroup and Subcabinet to the Commission and to State legislators regarding future bed need. Commission Staff recognizes that many of the recommendations to collect data in order to more accurately project need will take several years to fully implement. Based on data received from the Maryland Department of Human Resources, at any one time, there are 60 "Lisa L" youth awaiting placement to RTCs who presently are receiving treatment in either psychiatric hospitals or respite care facilities.[46]

In assessing the various issues facing the provision of these services to children and adolescents, Commission Staff also understands that there is a major conflict between, on the one hand, those stakeholders who do not think there is any need for additional RTC services and would rely on existing RTC facilities to provide the "Lisa L" population with access to RTC services and, on the other hand, those stakeholders who think additional RTC beds need to be projected to serve those in the "Lisa L" population awaiting placement.

8. Maryland's Community Access Planning Process and Olmstead vs. L.C.

The differences in approach to heath planning for this particular service sector will be played out in Maryland's community access planning process. With the issuance of Governor Parris N. Glendening's Executive Order, dated July 26, 2000, marking the tenth anniversary of the Americans with Disabilities Act, the State of Maryland became further engaged in a planning process to that would enhance the State's already accomplished record of planning efforts to serve persons with disabilities in the most integrated community-based settings. The Community Access Steering Committee was created to make recommendations to the Governor to enhance community-based services for individuals of all ages with disabilities. The Executive Order also created four task forces to assist the Steering Committee to develop recommendations for the Governor. One of the task forces was the Mental Health Community Access Task Force. The focus of this task force was to identify barriers and the development of strategies to expand community access for individuals with mental illness.

The Community Access Steering Committee was also formed in the wake of the United States Supreme Court's decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999). This case addresses important questions regarding the obligations of individual states to meet the needs of persons

[45] The MART is made up of representatives from the Department of Health and Mental Hygiene, Department of Human Resources, the Department of Juvenile Justice, the Maryland State Department of Education, and the Governor's Office for Children, Youth, and Families.

[46] Source: Maryland Health Care Commission Staff telephone conversations January – March, 2001with Jack Altfather, MART representative from Social Services Administration, Department of Human Resources.

with disabilities under Title II of the Americans with Disabilities Act ("ADA"). Olmstead is a landmark decision in the ongoing effort to allow all citizens to more fully participate in those programs that support community access and integration[47].

In considering how Maryland can move forward in its community access planning efforts, the Community Access Steering Committee's recommendations constitute an important link in this ongoing process, in providing a bridge from largely uncoordinated pre-*Olmstead* planning efforts to the post-*Olmstead* initiatives that are now being implemented. The Governor's Executive Order directs the Steering Committee to address the key questions that must be answered in order to accelerate the move to a clinically appropriate and programmatically sustainable system of community care. However, it is always essential to keep in mind that the community expansion efforts must face, and somehow overcome, real world limitations. Financial resources are limited. Staffing needs exceed available supplies. Infrastructure supports are critical to maintaining safe community placements. If these challenges are ignored the State of Maryland would risk "attempting compliance [with *Olmstead*] on the cheap, placing marginal patients into integrated settings devoid of the services and attention necessary for their condition." (119 S.Ct. at 2192)[48]

In addition to the challenges of serving the specialized treatment needs of mentally ill children and adolescents, there are the added uncertainties of access and quality facing all stake-holders in the provision of these services for young people with mental illness.

In planning to provide appropriate services, stakeholders should formulate plans that do not necessarily institutionalize children and adolescents. For those with chronic and persistent mental health problems, this can be very difficult to do. The challenge is to create a continuum of care that does not necessarily institutionalize children or adolescents, but does provide community-based systems of care, and also provides the level of service for specialized inpatient care commensurate with the needs of children and adolescents.

Surrounding all of these issues is an on-going debate within the RTC community over whether the focus of future planning should be on adding more RTC and other inpatient resources, or whether there should be more community-based services. The failure to resolve this debate impacts allocation of resources and, ultimately, inpatient capacity.

[47] Final Report of the Community Access Steering Committee to Governor Parris N. Glendening, July 13, 2001, pages 9-11.
[48] Ibid, p. 13

III. GOVERNMENT OVERSIGHT OF INPATIENT CHILD AND ADOLESCENT PSYCHIATRIC AND RESIDENTIAL TREATMENT CENTER SERVICES

Government oversight of both inpatient child and adolescent psychiatric and RTC services in Maryland--including facilities, staff and program operation-- falls under the purview of both federal and State government entities. Although this working paper focuses on responsibilities of the Maryland Health Care Commission, it is also important to consider how inpatient child and adolescent psychiatric and RTC services are regulated by other government agencies, particularly when considering a potential alternative to the current framework of Certificate of Need review.

A. Federal Level

1. Centers for Medicare and Medicaid Services ("CMS")

The Centers for Medicare and Medicaid Services ("CMS"), formerly the Health Care Financing Administration ("HCFA"), within the United States Department of Health and Human Services ("DHHS") is the federal agency that administers Medicare, Medicaid, and the State Children's Health Insurance Program ("SCHIP"). CMS provides health insurance for over 74 million Americans through Medicare, Medicaid, and SCHIP. In addition to providing health insurance, CMS also performs a number of quality-focused activities including regulation of laboratory testing, surveys and certification of health care facilities (including inpatient psychiatric hospitals and RTCs, and provides to beneficiaries, providers, researchers, and State surveyors information about these and other activities related to quality of care improvement.

2. Office of the Inspector General

The Office of the Inspector General ("OIG") within the federal DHHS is composed of the Office of Audit Services, Office of Investigations, the Office of Evaluation and Inspections, and the Counsel to the Office of Inspector General. The OIG works with CMS to develop and implement recommendations to correct systemic vulnerabilities detected during OIG/HHS investigations of care provided in health care facilities such as inpatient psychiatric facilities and RTCs. The OIG believes that an effective compliance program provides a mechanism that brings the public and the private sectors together to reach mutual goals of reducing fraud and abuse, improving the quality of health care services , and reducing the overall cost of health care.[49]

B. State Level

1. Department of Health and Mental Hygiene

The Maryland Department of Health and Mental Hygiene ("DHMH") develops and oversees public health programs with the goal of protecting the health of Maryland residents. A

[49] Source: www.hhs.gov/oig

highly complex organization with a broad scope of responsibility, DHMH is comprised of over 30 program administrations, 24 local health departments, over 20 residential facilities, and more than 20 health professional boards and commissions. The Maryland Medial Care Programs (the Medical Assistance Program ["Medicaid'] and the Pharmacy Assistance Program) are also located within DHMH.

a. Mental Hygiene Administration

One such administration within the DHMH is the Mental Hygiene Administration ("MHA"), which has as one of its responsibilities the oversight of the inpatient child and adolescent psychiatry and RTC services provided in State-funded facilities. This responsibility was significantly increased in 1997, when MHA assumed responsibility for Medical Assistance funds for mental health services. In that year, mental health care for Medicaid recipients was "carved out" from the remaining array of Medicaid medical (and substance abuse) services, which were restructured, pursuant to Maryland's 1115 (c) Medicaid Waiver, into managed care organizations, or "MCOs." In Maryland, the program is known as HealthChoice. MHA assumed responsibility for the combined State-Only and Medical Assistance funding for mental health services to Medicaid recipients and the resulting Public Mental Health System ("PMHS") also began to develop programs that included Medicaid recipients who were ineligible for the waiver MCOs as well as the so-called "gray area" patients who, due to income, were deemed ineligible for Medicaid.

MHA, in collaboration with the county-level Core Services Agencies, manages the public mental health system, both the inpatient psychiatric segment (including inpatient child and adolescent services) as well as a community-based services system. The Core Service Agencies ("CSAs") are the local mental health authorities responsible for planning, managing and monitoring public mental health services at the local level. CSAs exist under the authority of the Secretary of the Department of Health and Mental Hygiene and also are agents of the county government, which approve their organizational structure.[50] CSAs may develop comprehensive community-based plans to divert children and adolescents from hospital or RTC placement.

To carry out its responsibilities, MHA has contracted with an administrative service agency ("ASO"), Maryland Health Partners, a subsidiary of Magellan Behavioral Health, Inc., to manage such functions as eligibility and access to services, utilization review, the development of a management information system [the Crystal System], claims processing, and system evaluation. The MHA budget currently contains Medical Assistance and State general funds for the PMHS. This includes funding for services offered by the PMHS such as outpatient clinics and psychiatric rehabilitation, as well as inpatient psychiatric hospitalization, residential treatment center placement, services rendered by individual practitioners, mental health-related Early and Periodic Screening, Diagnosis, and Treatment ("EPSDT") services, and laboratory services.

In FY 2001, the latest data available, the Maryland legislature appropriated a total of $637.5 million for MHA. Of this amount, $396.2 million ($310.4 million was Medicaid funding) was for community services, $235.9 million was for State-operated institutions, and

[50] Source: www.dhmh.state.md.us/mha/pmhs

$5.4 million was for program administration. Federal grants to MHA included a Federal Block Grant, Projects for Assistance in Transitioning from Homelessness ("PATH"), Shelter Care Plus, and other grants through the Center for Mental Health Services which account for an additional $8.9 million in federal funding to Maryland citizens. Sixty-one percent of expenditures were for community services. For the number of children aged 17 and under with mental illness receiving services in Fiscal Year 2000, refer to Table 4 which also sets out the service type. The number of children and adolescents receiving services[51] increased from 7,500 in 1977 to 31,920 in 2001. The majority received services in the community as a result of MHA's emphasis on prevention and early intervention.[52] MHA is a member of the Subcabinet and the Multi-Agency Review Team.

Table 4
Medicaid Recipients and Uninsured Aged 17 and Under With Mental Illness Receiving Services, by Age[53]: Maryland, Fiscal Year 2000

Children Ages 17 and Under			
Service Type	M.A. + Uninsured	Medicaid	Uninsured
Case Management	638	587	51
Crisis	48	45	3
Inpatient	2,302	2,295	7
Mobile Treatment	189	178	11
Outpatient	27,741	26,689	1,105
Partial Hospitalization	236	236	0
Psychiatric Rehabilitation	3,656	3,559	99
Residential Rehabilitation	26	26	0
Respite Care	24	24	0
Residential Treatment	937	932	6
Supported Employment	10	9	1
FY 2000 Subtotals	35,807	34,580	1,283

Source: Final Report of the Community Access Steering Committee to Governor Parris N. Glendening, July 13, 2001, p.20.

b. Office of Health Care Quality

The Office of Health Care Quality ("OHCQ") is mandated by State and federal law to determine compliance with the quality of care and life safety standards for a wide variety of health care facilities and related programs, including child and adolescent inpatient psychiatric services, whether free standing or as units in a general hospital. OHCQ issues the "special hospital" license to all private psychiatric, State hospitals, and, in the case of acute general hospitals, "deems" them to meet State licensure standards, by virtue of their accreditation by the

[51] This includes all services including inpatient services.
[52] Final Report of the Community Access Steering Committee to Governor Parris N. Glendening, July 13, 2001, p. 18.
[53] Based **only** on Medicaid claims paid through March 31, 2001. These children and adolescents may have received more than one service; therefore, this is not an unduplicated count of children and adolescents served. (Source: Ibid., page 20)

Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"). RTCs have their own State licensure category. OHCQ's involvement in general hospitals is mainly limited to investigating complaints relating to quality of care issues from the general public, and complaints referred to it by the Maryland Insurance Administration.

c. Maryland Medical Care Programs (Maryland Medicaid and the Maryland Pharmacy Assistance Program)

Under the Maryland Medical Assistance Program ("Medicaid"), child and adolescent inpatient psychiatric hospital services and RTC services for eligible Medicaid recipients are reimbursed through the "carve-out" of Medicaid funds administered by the Mental Hygiene Administration and its contracted administrative services organization, Maryland Health Partners.

2. Department of Public Safety and Department of Juvenile Justice

The criminal and juvenile justice programs spend a significant amount of funding on drug and alcohol programs serving the criminal justice population. Treatment programs serving this population operate inside institutions or incarceration and within communities. These programs are not reviewed by CON, but provide a substantial proportion of overall treatment capacity. It should be noted that older adolescents are sometimes adjudicated by the adult criminal justice system when their crimes are of such severity that their cases are transferred to the adult criminal justice system.

The Maryland Department of Juvenile Justice ("DJJ") provides individualized care and treatment to youth who have violated the law, or who are a danger to themselves or others. Through a variety of programs, DJJ works closely with other state agencies, including the Departments of Education, Human Resources, Health and Mental Hygiene, and local agencies to efficiently and effectively work with young people and their families reach their full potential as productive and positive members of society. According to the State Health Plan, at COMAR 10.24.07, DJJ controls the admissions of violent juvenile sex offender RTC beds. Additionally, DJJ is responsible for providing mental health services to adjudicated youth within DJJ facilities and detention centers. DJJ is a member of the Subcabinet and a member of the MART.

3. Maryland State Department of Education

The Maryland State Department of Education ("MSDE") is charged with ensuring the right to a free and appropriate public education by implementing part B of the Individuals with Disabilities Education Act ("IDEA") for all educationally handicapped children from birth through the age of 20 years. It implements this charge within its Special Education Division, where services begin as soon as a child can benefit from them, regardless of age. COMAR 13A.09.10, Educational Programs in Nonpublic Schools and Child Care and Treatment Facilities, is used to approve educational programs in facilities by state agencies and in facilities operating special education programs such as RTCs. The MSDE is responsible also for developing an Individualized Education Plan ("IEP"), a written description of goals and the means that the educational facility plans to use to help each student achieve these goals in the

least restrictive environment. Representatives from local school systems participate on the local coordinating council and local management boards to plan for education services for the special education population. In an RTC, for Special Education students, the student to certified special education teacher ratio is 4 to 1; when the class size reaches 7 special education students, an educational aide is required. MSDE, too, is a member of the Subcabinet and a member of the MART.

4. Maryland Department of Human Resources

The Department of Human Resources ("DHR"), through its Social Services Administration, has the responsibility to determine eligibility for Medical Assistance, and to provide welfare services to children whose parents will not or cannot care for them. It also makes available a range of other services to children and families with special needs. These services include protective services to children, foster care, adoption, in-home aide services, day care, single parent services, respite care, intensive family services, services to families with children and family support centers. These services are provided primarily through the local departments of social services located in each of Maryland's 24 subdivisions. DHR is also a member of the Subcabinet, and a member of the Multi-Agency Review Team.

5. The Subcabinet /Office of Children, Youth, and Families

The Subcabinet for Children, Youth, and Families was created to promote interagency collaboration and increased partnership opportunities across the State in issues focused on children and their families. The Subcabinet provides leadership and policy direction and is comprised of the Secretaries of the Departments of Budget and Management, Health and Mental Hygiene, Human Resources, Juvenile Justice; the State Superintendent of Schools; the Special Secretary for Children, Youth, and Families; the Director of the Office for Individuals with Disabilities; and representatives from other State agencies as designated by the Governor. The Subcabinet Partnership Team addresses day-to-day operations and makes policy recommendations to the Subcabinet.

The Cabinet-level Governor's Office of Children, Youth, and Families ("OCYF") strives to provide support and assistance to help families nurture and care for their children. Established in May 1989 by Executive Order 01.01.1989.12, the Office for Children, Youth and Families believes that parents and local communities can best determine the strategies that will meet their children's needs. OCYF is a partner, facilitator, and collaborator with other State and local agencies, local management boards, and other community organizations. OCYF promotes child-centered, family-focused, and culturally-competent support to families.[54]

Initiatives under the leadership of the Special Secretary of OCYF include:

- Community Partnerships for Children and Families
- Governor's Council on Adolescent Pregnancy
- Governor's Commission on Infant Mortality Prevention

[54] www.ocyf.state.md.us

- Healthy Families Maryland
- Maryland School-Based Health Center Initiative
- State Coordinating Council for Residential Placement of Children with Disabilities
- Maryland Health Start Collaboration Office
- The Children's Trust Fund
- State Council on Child Abuse and Neglect

One of these initiatives, the Maryland State Coordinating Council ("SCC"), has specific relevance to child and adolescent inpatient psychiatric services and RTC services. To further monitor the State's long-standing concern for children who are placed in residential treatment, the SCC and the Local Coordinating Councils ("LCCs") were established during the 1980's as a strategy for bringing each agency's resources together for the benefit of Maryland's children needing residential placement.

The SCC was created by Executive Order in 1982; statutory language further detailing its authority and responsibility took effect in July 1987. In 1990, the SCC administratively moved to the Governor's Office for Children, Youth, and Families, and was incorporated in Article 49D. The guiding principles of the SCC/LCC are:

- to ensure that services are provided in a manner which most safeguards the rights of both parent and child;

- to utilize a structure that builds upon the strengths of existing procedures at the local level; and

- to provide an opportunity and incentive for resolution of interagency disputes at the lowest level possible.

The two primary goals for the SCC/LCC are[55]:

- to develop interagency plans for children to assure placement in the least restrictive environment appropriate; and

- to recommend to agencies the development of new and enhanced community-based programs to serve children with disabilities who might otherwise remain in restrictive placements that are distant (out-of-state or out-of-county) from their families and communities.

The members of the SCC include representatives from Maryland child-serving agencies: Department of Human Resources; Department of Health and Mental Hygiene; Department of Education; Department of Juvenile Justice; and the Office for Children, Youth, and Families and one nonvoting, ex officio representative of the Governor's Office for Individuals with Disabilities. By statute, members of the Local Coordinating Council, located in each county and Baltimore City, must include a representative from each of the following state or local agencies:

[55] Ibid.

- Mental Hygiene Administration
- Department of Juvenile Justice
- Developmental Disabilities Administration
- Alcohol and Drug Abuse Administration
- Local Board of Education (Local School System)
- Local Health Department
- Local Department of Social Services
- Local Management Board (LMB)
- Core Service Agency, and
- Division of Rehabilitation Services.

In addition, each LCC must have a parent advocate sitting, or available to sit, on the LCC as a nonvoting member to support the parent of a child referred to services

The SCC/LCC process has been in operation for almost 20 years (since 1982) in some jurisdictions, and has been fully operational since 1987 in all 24. Many individuals in local communities, therefore, are aware that this interagency resource is available. In addition, a representative of the Local Management Board is now a member of the LCC and through their participation they bring broad community concerns and commitment to ensuring this process is effective.

The State Coordinating Council ("SCC"), located in the Office for Children, Youth and Families, is the ongoing interagency collaboration responsible for ensuring that youth with disabilities are served in the most appropriate, least restrictive placement possible. The Council identifies new and enhanced community-based resources needed to serve youth who might otherwise be placed or remain in too restrictive and distant (out-of-state) placements.

Local Management Boards ("LMBs") were established throughout the State of Maryland as the conduit for collaboration and coordination of child and family services. With local child-serving agencies, local child providers, clients of services, and other community representatives, LMBs work with local stakeholders to address the needs of and to set priorities for their communities.

The authority for LMBs originates in Article 49D/Annotated Code of Maryland requiring each local jurisdiction to create an LMB and receive funding from the Subcabinet for Children, Youth, and Families. OCYF is charged with managing LMB grants and providing technical assistance to LMBs as needed. LMBs are on track in all of Maryland's 24 jurisdictions, engineering changes in their communities that will result in a better quality of life for children and families[56].

[56] Ibid.

6. Office of the Attorney General, Health Education and Advocacy Unit (HEAU)

The 1998 General Assembly passed the Appeals and Grievance Law to provide patients with an enhanced ability to resolve disputes with their health insurance carriers regarding denial of coverage by carriers.[57]The process outlined in the Appeals and Grievance Law begins with an adverse decision issued to the patient by the carrier. An adverse decision is a written decision by a health insurance carrier that a proposed or delivered health care services are not medically necessary, appropriate, or efficient. After receiving an adverse decision, a patient may file a grievance through the carrier's internal grievance process. The Health Education and Advocacy Unit of the Office of the Attorney General is available to attempt to mediate the dispute, or if necessary, to help patients file grievances with carriers.[58]

7. Maryland Insurance Administration

The Maryland Insurance Administration ("MIA") provides for the licensure of insurers and agents; establishes financial and capital standards for insurers of all types, and sets requirements for rate making and disclosure, and for fair practices. The MIA handles consumer complaints regarding coverage decisions and appeals of medical necessity decisions made by HMOs or insurers. The Administration's Division of Life and Health is responsible for regulating life, health (including mental health care), HMO, annuity, and dental plan insurance lines.

In an effort to provide customer information in the area of health insurance, including services provided for child and adolescent inpatient psychiatric hospitalizations and RTC care, the Maryland Insurance Administration publishes a series of publications including the following:

Health Insurance for Small Businesses-Rate Comparison Guide - provides a comparison of premiums for the Comprehensive Standard Health Benefit Plan for all health insurance companies using a model group.

Consumer's Guide to Health Insurance in Maryland - provides information about health care coverage, including an explanation of how health insurance works, types of health insurance available, shopping tips, options if consumers cannot afford health coverage, how to file a complaint, and frequently asked questions.

8. Health Services Cost Review Commission

The Health Services Cost Review Commission ("HSCRC") is empowered by Health-General Article §19-216 to review and approve the rates and costs of hospitals in Maryland. Its jurisdiction includes non-federal acute general hospitals, non-governmental chronic hospitals, and private psychiatric hospitals. In addition to establishing a uniform accounting and reporting

[57] Maryland Code Annotated, Insurance §15-10A-01 through §15-10A-09

[58] Office of the Attorney General, *Annual Report on the Health Insurance Carrier Appeals and Grievances Process, Health Education and Advocacy Unit*, Consumer Protection Division, November 2000

system, the HSCRC develops rate-setting policies and methodologies to carry out its functions. The HSCRC establishes psychiatric room rates for hospitals that have licensed acute psychiatric beds. Historically, the HSCRC has not established separate and distinct room rates for child and adolescent inpatient psychiatric services in the acute general hospitals; as it does for the private psychiatric hospitals.

Maryland is the only state in the nation with a rate-setting system that functions as an alternative to the federal Medicare prospective payment system, as provided in Section 1814(b) of the Social Security Act. The federal government reimburses waivered facilities in Maryland for hospital services provided to Medicare patients on the basis of rates set by HSCRC, rather than by its own prospective payment system. The federal government also accepts the hospital rates set by HSCRC with regard to federal financial participation in the Maryland Medical Assistance Program (Maryland Medicaid) for hospital services. In this "all-payer" system, hospitals may not grant discounts to any other payers unless HSCRC has approved them; HSCRC has allowed only limited discounts for some insurers. Maryland's waiver test is based on a comparison of average rates of increase in Medicare Part A payments per admission between Maryland and the rest of the country as a whole. Good performance on the test will reflect improvements in controlling Medicare payments under the federal perspective payment system.

9. Maryland Health Care Commission

Through the health planning statute, the Maryland Health Care Commission ("MHCC") is responsible for the administration of the State Health Plan, which guides decision making under the Certificate of Need program and the formulation of key health care policies, and the administration of the Certificate of Need program, under which actions by certain health care facilities and services are subject to Commission review and approval[59]. Through the Certificate of Need program, the Commission regulates market entry and exit by the health care facilities and individual medical services covered by CON review requirements, as well as other actions the regulated providers may proposed, such as increases in bed or service capacity, capital expenditures, or expansion into new service areas. The Commission has developed State Health Plan chapters in response to requests from the Subcabinet and other child serving agencies.

"Certificate of Need" as a regulatory tool has three levels, each initiated by a written notice or letter of intent to the Commission. For confirmation that a Certificate of Need is not required to establish a certain kind of health care facility or service, a person requests a "determination of coverage" by CON requirements. Staff and counsel then analyze the proposal according to the Commission's statute and applicable regulations, and, if CON review and

[59] The MHCC also establishes a comprehensive standard health benefit plan for small employers, and evaluates proposed mandated benefits for inclusion in the standard health benefit plan. In its annual evaluation of the small group market, the Commission considers the impact of any proposed new benefits on the mandated affordability cap of the small group market's benefit package, which is 12 percent of Maryland's average wage, and the impact of any premium increases on the small employers. Briefly, with regard to mental health and substance abuse, this is covered when delivered through a carriers' managed care system for 60 inpatient days with partial hospitalization traded on a 2 to 1 basis and unlimited outpatient visits subject to the following cost sharing: in-network carrier pays 70%; out-of-network carrier pays 50%. Prescription drugs are covered with a $150 separate deductible for each covered person, and an open formulary with a three-tiered co-payment.

approval are not needed to undertake the project, the Executive Director issues a determination to that effect as the Commission's designee.

Proposed new health care facilities and specified actions by existing facilities that do require CON approval come to the Commission either in response to a schedule regularly published in the *Maryland Register*, or, if no schedule has been published for a particular service, as an unscheduled review. Procedural rules dictate how unscheduled reviews must be administratively handled so as to permit a comparative review for the new service, if that is appropriate or practical. The CON review itself proceeds according to additional rules set forth at COMAR 10.24.01, evaluates an application against all applicable standards and need projections for the service in the State health Plan, and applies six general review criteria related to the need for and the likely impact of the proposed project on the health care system. Statute requires that Commission Staff (or a Commissioner appointed as a reviewer in a comparative review) bring a recommendation on a proposed project to the full Commission within 90 days of docketing[60]. The first thirty days after docketing are set aside as a period for public comment, in which interested members of the public, as well as "interested parties" in the legal sense, may comment on the proposal or, if they meet criteria in regulation, enter the review in opposition to the project.

Since 1985, the health planning statute has permitted the Commission to find, "in its sole discretion," that certain actions taken by existing health care facilities—if the facilities proposing them are merging, or have merged and are proposing to further consolidate or to reconfigure their bed capacity or services—may be exempted from the Certificate of Need requirement that would otherwise apply. This so –called "exemption" from the CON requirement may be granted through action by the Commission for several kinds of actions proposed "pursuant to a consolidation or merger" of two or more health care facilities, if the proposed action:

- Is "not inconsistent with" the State Health Plan[61];
- "Will result in the delivery of more efficient and effective health care services";
- Is "in the public interest."[62]

A merged asset system seeking a finding by the Commission must provide notice of its intent at least 45 days before it requests action on the proposal. Additional procedural regulations (at COMAR 10.24.01.04C) require the Commission to provide notice to the public, with the opportunity to comment on the proposed action.

[60] Docketing is the formal start of a CON review; the time period in which a recommendation is to come to the full Commission is 150 days, if an evidentiary hearing is held. However, 1995 legislation to streamline the CON review process mandated the adoption of regulations that restrict an evidentiary hearing to those cases in which the "magnitude of the impact" of a potential new facility or service merit the additional time and transactional cost.
[61] Or the institution-specific plan developed and adopted by the Commission," pursuant to its authority at health-General Article §19-122, Annotated Code of Maryland.
[62] Health-General §19-123(j)(2)(iv)

Market Entry

Entry into the market for proposed new inpatient child and adolescent facilities or bed capacity has been explicitly regulated through Certificate of Need since the 1988 enactment of a list of "medical services" subject to CON, if established by an otherwise-regulated health care facility[63]. As with all Certificate of Need review in Maryland, the analysis of applications for CON approval for new facilities or expanded bed capacity[64] in either case of these two "special hospital services evaluates how proposed projects meet the applicable standards and policies in the State Health Plan, and how they address the six general review criteria found in the Certificate of Need procedural regulations at COMAR 10.24.01.07.[65] The State Health Plan currently in effect requires that a facility obtain a separate Certificate of Need for each division of inpatient psychiatry recognized by the SHP, i.e. a designated child, adolescent, or adult psychiatric service.

The State Health Plan rules and standards that are applied to CON reviews of proposed new facilities or expansions fall into several distinct categories, including:

- **docketing standards,** which determine whether applications for new facilities or expansions will be accepted and may be docketed for review;
- **review standards,** which are applied to all applications, and provide a composite description of what the Commission has established –through its staff research, deliberation, and the public adoption process –should characterize a facility or service of the kind under review;
- **approval rules,** which set threshold standards that must be met, or a proposed project may not be recommended for Commission approval; and
- **modification rules,** which guide the review of certain kinds of changes proposed to projects already granted Certificate of Need approval.

The method of projecting future need for child and adolescent inpatient psychiatric services is regional; and, in the case of RTC services, it is both regional and statewide [the SHP needs for violent juvenile sex offenders is a statewide assessment, whereas "Lisa L" projects bed need in the Central Maryland region]. This approach for bed need projection distinguishes these types of services from other medical services provided in the hospital setting.[66]

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[63] Health-General §19-123(a).

[64] Bed increases in either service may be authorized by the commission without CON review through the statutory "waiver bed" rule that permits increases of 10 beds or 10% of total beds, which ever is less, two years after the last change in licensed bed capacity.

[65] In brief, these criteria require an application to: (1) address the State Health Plan standards applicable to the proposed project; (2) demonstrate need for the proposed new facility or service; (3) demonstrate that the project represents the most cost-effective alternative for meeting the identified need; (4) demonstrate the viability of the project by documenting both financial and non-financial resources sufficient to initiate and sustain the service; (5) demonstrate the applicant's compliance with the terms and conditions of any previous CONs; and (6) "provide information and analysis on the "impact of the proposed project on existing health care providers in the service area."

[66] With the scheduled June 21, 2001 release for public comment of a new State Health Plan chapter for Acute Inpatient Obstetric Services, COMAR 10.24.12 (prior to its formal proposal as permanent regulations), obstetrics would become the second acute hospital service not subject to a jurisdictional need projection threshold. The

Market Exit

As noted in previous discussions in Phase I of this report concerning the effect of HB994 and its changes to Certificate of Need law applicable to "the closure of a hospital or part of a hospital," two of these 1999 statutory provisions significantly altered the Commission's oversight authority with regard to potential closures of hospitals or their inpatient psychiatry services, and with regard to the bed capacity of individual medical services.

The Certificate of Need procedural rules applicable to hospitals in jurisdictions with three or more hospitals at §19-123(l) explicitly include State hospitals, which also may close without action by the Commission, provided that the Commission has received written notification 45 days before the planned closure, and the hospital (or in this case, the Department of Health and Mental Hygiene, specifically, the Mental Hygiene Administration) has held a public informational hearing in the area affected by the closure. State statutes and regulation require that an RTC receive a Certificate of Need to close a facility. However, if a facility were required to close as a result of an impending bankruptcy or violations of licensing or certification standards, which have resulted in a closure by the Office of Health Care Quality, the Commission has not required a CON review.

It is far less clear whether this comparatively quick and easy closure process also applies to the private psychiatric hospitals, which are not classified as general hospitals under the licensure statute.[67] Interpretations of the provisions of HB994 related to acute general hospitals are based on their inter-connectedness: the bill ended the creation of waiver, or "creep" beds in general hospitals (this was clarified in the Commission's implementing regulations), in favor of the annual recalculation of licensed bed capacity "for a hospital classified as a general hospital,[68]" according to a factor of 140% of its previous year's average daily census. HB994 has not been interpreted as precluding the authorization of waiver beds for private psychiatric hospitals, and it has not been interpreted as permitting any but acute general hospitals (i.e., those subject to the annual application of 140% of last year's average daily census) to increase or decrease beds between members of merged asset systems.

development of this new plan section follows the Commission's recommendation to the Maryland General Assembly, conveyed in the Phase 1 Final Report in the legislatively-mandated study of Maryland's CON program.

[67] Health-General Article §19-307(a).

[68] Health-General Article §19-307.2(a)

IV. MARYLAND'S CERTIFICATE OF NEED REGULATION OF INPATIENT CHILD AND ADOLESCENT PSYCHIATRIC AND RTC SERVICES COMPARED TO OTHER STATES

Thirty-six states plus the District of Columbia, as shown in the latest national directory published by the American Health Planning Association ("AHPA") (See Table 5), have Certificate of Need review for some number of health care facilities and proposed expansion of service capacity. Maryland ranks in the lower third of what the AHPA terms its "Relative Scope and Reviewability" ranking which lists the CON states in descending order, beginning with those with the most covered services and lowest capital and service review thresholds. Maryland is noted as one of twenty-six states that regulates psychiatric services.

In an effort to learn what other states are doing with regard to the regulation, by means of a Certificate of Need review program of either child or adolescent inpatient psychiatric services or residential treatment center services, Commission Staff contacted other states by means of electronic mail communication through an internet forum established by the American Health Planning Association. Through this forum, staff received a total of eight (8) responses from Staff from other states' health planning units.

A representative from the State of Ohio responded that the state does not review either of these services through the CON program.[69]

Staff from the Central Virginia Health Planning Agency responded that Virginia is in the process of reviewing all services included in the State Medical Facilities Plan, including psychiatric services. Currently, in Virginia, all psychiatric service is grouped together for regulatory purpose, a situation that is problematic. There is no separate licensure or need methodology for child or adult services, or acute inpatient or residential treatment center services. Moreover, there are no adjustments for acuity, and others needing single, locked rooms, where the facility only has semi-private rooms. This creates lower occupancies and less efficient utilization of facilities.[70]

Staff from the State of Arkansas responded that Arkansas currently requires a CON for all psychiatric residential treatment facilities for children and youth. The formula that Arkansas uses is .385 beds per 1,000 persons age 6-17 and .300 beds per 1000 persons aged 18-21. Facilities requesting additional beds must have averaged a 90% occupancy rate for the previous calendar year. In order for a new facility to be approved for a given county, existing facilities in that county must have averaged an 80% occupancy rate for the previous calendar year.[71]

In Florida, the CON review process regulates licensed hospitals for children's mental health services, according to staff from the Florida Hospital Administration; however, not other

[69] Electronic mail communication from Christine Kenney, Ohio Department of Health, September 21, 2001.
[70] Electronic mail communication from Karen L. Cameron, CHE, Executive Director/CEO, Central Virginia Health Planning Agency, Richmond, Virginia, September 21, 2001.
[71] Electronic mail communication from Mary Brizzi at the Arkansas Department of Health, September 21, 2001

types of residential treatment settings—although one type of licensed hospital bed for psychiatric services is called "intensive residential treatment facility". CONs are required in Florida in order to open specialty hospitals providing psychiatric services for children or adults through units in general hospitals. Florida also requires CONs for the expansion of bed capacity in either freestanding/specialty hospitals or units in general hospitals. Florida's regulations project need for children's mental health beds in two categories—psychiatric and substance abuse. The regulations use current use rates in each of 11 health planning districts applied to future population to predict gross bed need and then to adjust the need numbers based on occupancy at existing hospitals. In the most recent bed need projections, staff from the Florida Association reports, only one district was found to have a need for children's psychiatric beds (53 beds), and no districts were found to have any need for substance abuse beds (even though licensed beds exist in only 1 district).

According to Florida's most recent CON Annual Report, published by the Florida state health planning agency, CON activity for these types of beds has been very limited in the last ten years—with only 17 applications being filed during this period for child psychiatric services, and no applications being filed for children's substance abuse beds. When new beds have been approved, they have mostly been by means of conversion or transfer. Only 4 psychiatric beds, in the last five (5) years have been added through new construction; the Florida Hospital Administration staff did not know whether these were child or adult beds.

Possibly one explanation for this limited activity for these types of services in Florida is that when Florida first recognized children's psychiatric beds and substance abuse beds as distinct licensure categories in 1991, the state inventory listed 1,841 licensed beds as child psychiatric along with 259 as child substance abuse beds. Since 1992, this inventory has declined markedly, to 606 licensed beds for children's psychiatric services, with 15 licensed beds for children's substance abuse services.[72]

CON staff from the state of Missouri responded that the state does little to regulate inpatient child and adolescent psychiatric services by means of a Certificate of Need since it has have found that the proposed service rarely goes over Missouri's $1,000,000 expenditure minimum for CON review.

The state of Michigan regulates child and adolescent inpatient psychiatric services with a need methodology, the base year of which, according to its regulations, Michigan's CON Commission may modify. It is also interesting to note that a requirement for approval of a CON for child and adolescent inpatient psychiatric beds is that the average occupancy rate for all licensed beds at the psychiatric hospital or unit shall be at 75% for the second 12 months of operation, and annually thereafter. The State of Michigan's definition of a "specialized psychiatric program" is very much like Maryland's residential treatment center. Projects involving either an increase in the number of beds (whether new, additional, replacement or converted) for a specialized psychiatric program for children or adolescents are subject to a comparative review.

[72] Electronic mail communication from Carol J. Gormley, Director of Governmental Relations, Florida Hospital Association, Tallahassee, Florida, September 21, 2001.

As of October 1, 2002, Michigan will be eliminating CON regulation of partial hospitalization psychiatric programs. These programs are defined as follows:

> "a non-residential mental health treatment program in which clients are regularly scheduled to be treated for a minimum of six consecutive hours during any 24-hour period for a minimum of five (5) days per week; including psychiatric, psychological, social, occupational, therapeutic recreational elements, all of which are under psychiatric supervision; and provides services to clients who are diagnosed mentally or emotionally ill , and who are at risk of psychiatric inpatient hospitalization, or who might otherwise remain hospitalized on an inpatient basis in the absence of such a program.[73]"

Staff involved in CON review responded that South Carolina does not have separate bed need calculations or standards for inpatient child psychiatric beds. Any beds proposed must come from the general bed need, which the staff noted was currently negligible [with only two out of 14 service areas showing a need for psychiatric beds]. In South Carolina, adolescents can remain in an RTC up to age 21, whereas in Maryland it is up to the age of 18. South Carolina has CON standards and a bed need methodology projected by regional service area for RTCs. The standards note what minimum services should be available at a minimum. RTC beds for children and adolescents are distributed statewide, and are located within seventy-five (75) minutes travel time for the majority of residents of the state. South Carolina gives equal weight to the benefits of improved accessibility with the adverse affects of duplication in evaluating Certificate of Need applications for this service.[74]

Staff from the State of Kentucky responded that its State Health Plan states "no new psychiatric beds for children or adolescents shall be approved except for beds converted from existing acute care beds. No psychiatric beds for children or adolescents focus on short-term (under 30 days) crisis stabilization." Kentucky also regulates psychiatric residential treatment facilities that are community-based, home-like eight bed facilities for ages six to 21[75].

[73] Electronic mail communication from Catherine Stevens, Michigan CON Commission, Michigan Department of Public Health, September 21, 2001.
[74] Electronic mail communication from Les Shelton, South Carolina Department of Health and Environmental Control, September 24, 2001.
[75] Electronic mail communication from Jayne M. Arnold, Kentucky Health Service, October 2, 2001.

TABLE 5
COMPARISON OF NUMBER AND SCOPE OF HEALTH CARE FACILITIES & SERVICES COVERED IN STATES WITH CON PROGRAMS

RANK[76]	STATE[77]	Psychiatric Svcs	Substance Abuse	Acute Care	Air Ambulance	Amb Surg Ctrs	Burn Care	Business Cmptrs	Cardiac Cath.	CT Scanners	Gamma Knives	Home Health	ICF/MR	Lithotripsy	Long Term Care	Med Off Bldg	Mobile HiTech	MRI Scans	Neo-ntl Int Care	Obstetric Svcs	Open Heart Svcs	Organ Transplant	PET Scans	Radiation Therapy	Rehab	Renal Dialysis	Res Care Fac	Subacute	Swing Beds	Ultrasound	Capital Threshold	Other Services[78]
31.2	ME	X	X	X	X	X	X		X	X	X		X	X	X		X	X	X	X	X	X	X	X	X	X			X	X	X	
30.0	GA	X	X	X		X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X		X		X	X
28.6	CT	X	X	X	X	X	X	X	X	X	X			X	X	X	X	X	X	X	X	X	X	X	X		X		X	X	X	X
27.0	AK	X	X	X	X	X	X		X	X	X	X		X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
25.2	WV	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X	X
22.5	VT	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X	X	X	X	X	X	X	X			X		X	
21.0	MO	X	X	X		X			X		X		X	X	X		X	X	X	X	X		X	X	X	X	X	X			X	X
20.9	SC	X	X	X		X			X		X	X	X	X	X		X	X	X	X	X		X	X	X			X			X	
19.2	NC	X	X	X	X	X	X		X	X	X	X	X	X	X		X	X	X		X	X	X	X	X	X			X		X	X
18.0	MS	X	X	X		X			X		X	X	X	X	X			X			X		X	X	X	X	X		X		X	
16.1	DC	X	X	X		X			X	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X			X	X		X	
16.0	TN	X	X	X	X	X			X	X		X	X	X	X			X	X		X		X	X	X			X	X		X	X
16.0	AL	X	X	X		X			X		X	X		X	X			X	X	X	X	X	X	X	X	X			X		X	X
15.3	**MD**	**X**	**X**	**X**		**X**	**X**		**X**			**X**	**X**		**X**				**X**	**X**	**X**	**X**			**X**			**X**	**X**		**X**	**X**
15.2	RI	X	X	X		X			X	X	X				X		X	X	X	X	X	X	X	X	X			X	X		X	
15.0	HI	X	X	X	X	X	X		X	X	X	X	X	X	X		X	X	X	X	X	X	X	X	X	X		X	X		X	
14.4	MI	X		X	X	X			X	X	X			X	X		X	X	X		X	X	X	X					X		X	X
14.4	KY	X		X		X			X			X	X	X	X		X	X	X		X	X		X	X		X	X			X	X
13.3	IL	X		X		X	X		X		X		X		X	X			X	X	X	X	X	X	X	X			X	X	X	X
13.2	NJ	X		X			X		X			X	X		X				X		X	X			X		X				X	
13.2	NY	X	X	X		X	X		X	X	X	X	X	X	X		X	X	X		X	X		X	X	X			X	X	X	
12.6	WA			X		X	X					X			X				X	X	X	X			X	X		X	X		X	X
11.7	NH	X	X	X		X			X	X				X	X		X	X			X			X	X						X	
8.4	AR											X	X		X												X	X	X		X	X
8.1	IA					X			X				X		X						X	X	X	X							X	X
8.0	VA	X	X	X		X			X	X	X		X	X	X		X	X	X	X	X	X	X	X	X						X	X
7.7	FL	X	X	X			X						X		X				X		X	X						X				X
7.0	OK	X	X										X		X																	X	X
6.3	MT		X			X						X	X		X											X			X		X	
4.8	MA	X	X		X	X					X			X	X			X	X		X	X	X	X	X		X				X	X
4.8	DE			X		X			X					X	X								X	X							X	X
4.4	WI												X		X													X			X	X
3.5	NV		X	X		X							X		X										X			X			X	
3.0	NE														X										X						**	
2.4	OR														X														X		**	
1.0	OH														X																X	X
0.4	LA												X		X																	

This chart is adapted from the American Health Planning Association's annual graphic, last updated in AHPA's 2001 Directory of Health Planning Policy & Regulatory Agencies (12th ed.), which compares the "National Relative Scope and Reviewability Threshold of CON Regulated Services" among the states. The 2001 version of AHPA's graphic contained some errors with regard to Maryland's services, which have been corrected in Staff's adaptation. Consequently, the "severity" index as calculated according to several factors, including number of services regulated and level of capital review threshold, may not precisely reflect Maryland's "weight" or "severity" according to AHPA's formula, compared to other CON states. However, the chart's relative position of Maryland's CON program--which does not cover a significant number of health care facilities and services regulated by many other states--would still be in the middle range of CON programs, nationwide.

** Any capital expenditure for LTC

[76] No. of services x weight as determined by the Missouri CON Program.
[77] Including the District of Columbia.
[78] Services in addition to those most often CON-regulated.

V. ALTERNATIVE REGULATORY STRATEGIES: AN EXAMINATION OF CERTIFICATE OF NEED POLICY OPTIONS CHILD AND ADOLESCENT INPATIENT PSYCHIATRIC SERVICES AND RTC SERVICES

The options discussed in this section represent alternative strategies governing oversight of inpatient child and adolescent psychiatric services and RTC services in Maryland. Each of these services is considered separately, with its potential alternative regulatory frameworks taken up separately.

The role of government in these options describes a continuum varying from the current role with enhanced data collection (Option 1), to a more expanded role (Option 2), to an extremely limited role (Option 6). The options below, singly or in combination for either service, suggest potential alternative strategies that could be considered in relation to the larger issue of how Maryland should regulate child and adolescent inpatient hospital services and RTC services. As with the options presented by the staff Working Papers during Phase I of the Certificate Of Need Working Paper, this is not an exhaustive list of options. The Commission expects and encourages the submission of other options and ideas through the public comment process. All categories of inpatient psychiatric beds are regulated by the State Health Plan, whereas only the specialty RTC populations ("Lisa L" and Violent Juvenile Sex Offenders) are addressed by individual sections of the SHP chapter COMAR 10.24.01.07. Therefore, the options below will apply differently to child and adolescent psychiatric hospitals when compared with RTCs.

Option 1: Maintain Existing Certificate of Need Review Program Regulation for Child and Adolescent Inpatient Psychiatric Beds and RTC Beds, With Commission-Mandated Data Collection for RTC Beds

This option would maintain the CON review requirement for new or expanded child and adolescent inpatient psychiatric and RTC services in current law and regulation, but with the addition of Commission-mandated data collection for RTC beds. Under current law, establishing a new inpatient child and adolescent psychiatric hospital requires a CON based on a state-projected need. The Commission's decision on a given application is based on its review of a proposed project's consistency with the State Health Plan's review standards and consensus with other stakeholders about need projection, along with the general CON review criteria. To exit from this market, the provider would have to hold an informational public hearing, and provide the Commission with written notification of the intended closure of the child and adolescent inpatient psychiatric hospital. CON exemption by Commission action is required.

ith regard to RTCs, only the "Lisa L" and violent juvenile sex offender populations are addressed in the SHP. Those wishing to develop an RTC serving other specialized populations or a generic RTC would have to petition the Commission to increase its depth and scope to cover the appropriate population. (See Option 2).

This option would also address the Commission's long standing need for planning specific data that measures utilization in relation to the capacity of the system, and the systematic

monitoring of the system to show fluctuations, and to project short and long term system trends, none of which can be accomplished through existing data systems. The expansion of the Commission's data collection authority to encompass RTC facilities would require additional resources. This is an extension of the Commission's involvement.

Option 2: Expand Certificate of Need Program Regulation

Under existing health planning law, the closure of an inpatient psychiatric service requires either a 45-day notice or an exemption from CON review, depending upon the number of hospitals in the jurisdiction. The closure of a State hospital or part of a State hospital requires only the 45-day notification, regardless of the jurisdiction. Restoring the statutory requirement for some level of action by the Commission in all proposed closures of inpatient psychiatric services in acute general hospitals is a second alternative regulatory strategy. A finding by the Commission that exempts a proposed hospital service closure from CON review is currently needed in jurisdictions with one or two hospitals; only notice to the Commission and a public hearing is necessary for service closure in a multiple hospital jurisdiction. Option 2 would strengthen current oversight of inpatient psychiatric service closures by requiring hospitals in multiple hospital jurisdictions to obtain an exemption to exit the market.

This option supports placing greater public policy emphasis on insuring geographic access to inpatient psychiatric services (including child and adolescent psychiatric services). This option does not apply to RTCs.

The recent hospital closures at Gundry-Glass Hospital and Chestnut Lodge may well have affected future access to care for mentally ill children and adolescents. Current statute allows hospitals in multiple hospital jurisdictions, including Baltimore City, to close without Commission oversight or action, after notification and a public hearing. Requiring the same level of review for multiple hospital jurisdictions as now exists in one- or two-hospital jurisdictions would allow public review and community input into the potential impacts and solutions of the closure of a child and adolescent psychiatry service in all areas of the State. On the other hand, it must be noted that this option modifies previous efforts at CON liberalization by re-imposing some level of review (i.e., exemption) that has been eliminated from statute for hospitals in the most populous Maryland jurisdictions.

Expansion of regulation regarding RTCs would first require the development of a State Health Plan section within COMAR 10.24.01.07, or the creation of a separate SHP chapter to address all RTCs. This could then be followed by expanding services in specialized RTC treatment settings, or through the development of a chapter that projects overall RTC need. This could be further enlarged by also including respite care, as it is presently constituted, which has become a much longer length of stay with services that mirror an extended stay hospital setting. Both these expansions in regulations are predicated upon the development of new databases that would supply relevant data to make informed planning decisions.

Option 3: Partial Deregulation of Child and Adolescent Inpatient Psychiatric Services and RTC Services

A. Maintain Regulation of Child/Adolescent Hospital Facilities But Deregulate Planning for RTCs to the Subcabinet

As previously mentioned, planning for RTC services requires a broad consensus among stakeholders. As encouraged by its regulations,[79] the Commission, in CON reviews for RTCs and child/adolescent hospital facilities routinely seeks the opinion of the Subcabinet in the determination of bed need.[80] The rationale for maintaining regulation of hospitals is that this would maintain the continuity of planning for hospitals statewide within the MHCC. The rationale for transferring responsibility for RTC bed planning to the Subcabinet is that these decisions would have a direct impact on planning, budgeting, and legislation relating to all children and adolescents in the State, responsibilities which rest with the Subcabinet. This option could lead to better coordination of services because the same entity would be responsible for the planning for RTCs and community-based services for this population, thereby contributing to better coordination of all services.

B. Deregulate from Certificate of Need Review Child/Adolescent Hospital Facilities and Maintain Regulation and Planning for RTCs to the Commission

The *Working Paper: Inpatient Psychiatric Services* suggested an option that would remove the requirement for a separate Certificate of Need review and approval for an additional divisions of care, if the facility seeking to expand its service capabilities already operates one of the age-specific designated psychiatric services. This option would limit only hospital facilities with an existing adult- or combination of an adult- and other age group unit to add either one or both, a child or adolescent psychiatric unit(s).

The procedural means of obtaining the additional service division or divisions could either involve an exemption from Certificate of Need review, which would require an expedited 45-day Staff review, or a recommendation to the Commission that the proposed addition is "not inconsistent with the State Health Plan," would result in a more efficient and effective delivery of health care services, and would be in the public interest. Alternatively, the addition of another division of designated inpatient psychiatric beds could be accomplished through a determination of non-coverage by Certificate of Need review.

The key factor in a Staff analysis – under either level of review procedure in this option – would be the commitment of the hospital proposing to add one or more service divisions to an operating adult inpatient facility or unit to meet the existing State Health Plan requirements for the separate service designations. Perhaps the most important of these is the requirement that a facility operating units for children, adolescents, or adults on the same site "must provide that physical separations and clinical/programmatic distinctions are made between different patient

[79] COMAR 10.24.01.17E

[80] In addition to the recent RTC workgroup, on March 31, 1995, the then Executive Director of the Maryland Health Resources Planning Commission signed a Memorandum of Understanding between the Subcabinet and the Health Resources Planning Commission.

groups."[81] A requirement could be considered for inclusion in the Plan's standards to be applied in a Staff analysis of a proposed new division of psychiatric service, that the program employ a Board-certified/eligible child and adolescent psychiatrist. This option presumes that an existing provider presents certain advantages, of available expertise and experience, of quality assurance and outpatient services already in place as well as the ability to refer to other step-down child/adolescent treatment and support services. Making the addition of child/adolescent psychiatric services easier administratively – provided that the minimum quality and qualifications were present – could potentially prove enough of an incentive for hospitals with existing adult psychiatry services that more child and adolescent beds might come into the system.

This option would, however, maintain regulation of RTC services by the Commission. The Commission has the knowledge, experience, and expertise to adequately plan for the entire system of child and adolescent inpatient care. No other governmental entity in the State has the statutory mandate to plan for both the public, private, and non-profit sectors of the health care system. The Commission is, and continues to be, situated where it can act as an arbiter among the child-serving agencies, providers, advocates and other stakeholders because its constituency comprises the entire State.

Option 4: Deregulation of Inpatient Child and Adolescent Psychiatric Facilities from CON Review With Responsibility for Monitoring Transferred to the Mental Hygiene Administration/the Subcabinet or the Office for Children, Youth, and Families

As noted above, MHA is responsible for administering the Public Mental Health System as well as General Assembly-appropriated funds that support inpatient and outpatient programs. Given its planning and financial responsibilities, it is natural and logical to assign responsibility for the monitoring of need to those who are statutorily accountable to the legislature for the majority of the funding of child and adolescent psychiatric facilities. MHA plans for services, collects data, and assures that quality programs are available for the citizens of Maryland, including children and adolescents.

A similar rationale for the deregulation of child and adolescent psychiatric facilities and deferring to MHA would apply to either the Subcabinet or the Office for Children, Youth, and Families. Since the Subcabinet is comprised of representatives of all of the child-serving agencies plus representatives of the Department of Budget and the Office of the Attorney General, this agency would also have the expertise and experience to monitor planning for these services. Likewise, the Office for Children, Youth, and Families would have similar capabilities.

Option 5: Deregulate Child and Adolescent Psychiatric Services from Certificate of Need Review; Create Data Reporting Model to Encourage Quality of Care

Another option for child and adolescent psychiatric service regulation involves replacing the CON program's requirements governing market entry and exit with a program of mandatory

[81] COMAR 10.24.07, Policy 4, page AP-4

data collection and reporting, to encourage continuous quality improvement through the gathering and periodic publication of comparative information about existing programs. Performance reports, or "report cards" are intended to incorporate information about quality decisions made by both employers and employees in their choice of health plans, and by consumers whose health plans permit a measure of choice in providers. Performance reports can also serve as benchmarks against which providers can measure themselves, and seek to improve quality in any areas found deficient. As such, report cards may both inform consumer choice and improve the performance of health services. Report cards for inpatient child and adolescent psychiatric services could be implemented in at least two ways: public report cards, designed for consumers, or performance reports designed to provide outcomes information and best-practices models for providers.

A. Consumer-Oriented Specific Public Report Card for Child and Adolescent Inpatient Psychiatric Services

This option would create a vehicle for public reporting of basic service-specific information in a report-style format, promoting consumer education and choice. Behavioral health service report cards could be designed to report on facilities, physicians, or provider groups, or a combination. In response to a 1999 legislative mandate, the Commission is proceeding with the development and implementation of hospital and ambulatory surgery facility report cards, similar to the HMO report cards the Commission currently produces. Therefore, this option for child and adolescent inpatient psychiatric services could be considered a component of the planning for acute general hospital or other behavioral report card, perhaps as a subject of a future supplementary report. This could be eventually extended to the private psychiatric hospitals, and potentially even to State hospitals and RTCs.

B. Provider Feedback Performance Reports

Under this option, the Commission, or another public or contracted private agency, would establish a data collection and feedback system designed for use by providers. Like the report card option, this involves mandatory collection of detailed outcomes and process information from all hospital and RTC inpatient services to measure and monitor the quality of care using a selected set of quality measures specific to these services. This option is consistent with the recent national policy debate regarding the need for more information and improved outcome accountability. While CON typically serves as a means to create and allocate new facility-based medical service capacity on a rational, planned basis, and is not generally intended to monitor quality after an approved program begins operation, this option does further that objective.

Option 6: Deregulation of Child and Adolescent Inpatient Psychiatric Services and Residential Treatment Centers from Certificate of Need Review

Certificate of Need as a regulatory tool to control cost or address quality of care has been questioned by advocates for a totally market-driven, entrepreneurial approach to establishing and providing health care services. In Maryland, it can be argued that quality of care, once a CON-approved facility or service begins operating, is addressed by the standards of JCAHO and the Office of Health Care Quality. It could also be argued that since a large percentage of funding for treatment has been transferred from the private sector to the public sector that those who

budget the funding of these services should be responsible for the planning of these services. Under this option, all CON review related to both market entry and exit would be eliminated for child and adolescent inpatient psychiatric services and residential treatment centers in Maryland.

Repeal of CON has been associated with increases in supply of services in several states. The concerns relating to reimbursement and length of stay constraints affecting these particular services may have different effects on each service. It is unlikely that there would be an increased supply of child and adolescent hospital beds if there were to be complete deregulation of the service because of the continued denial of admission and pervasive constraints on length of stay by managed care. However, there does not seem to be the same constraints placed upon RTC admission and length of stay; and therefore, it would be more likely that the result would be an increased supply of RTC beds.

Additionally, the expansion of child and adolescent psychiatric hospital services or residential treatment centers would have to face the problems of professional staffing already in short supply and who need to be available 24/7 basis.

In the absence of CON oversight by this Commission, governmental oversight would come from existing agencies such as the Office of Health Care Quality, the Mental Hygiene Administration, and the Medicaid program.

V. SUMMARY

Child and adolescent psychiatric services are among the medical services defined in health planning statute that requires a CON to establish and, in some cases, to expand in a hospital. This report examines the current policy and regulatory issues affecting child and adolescent inpatient psychiatric services and RTC services, and outlines several alternative policy options for changes to CON regulation, and the potential implications of those changes. Table 5 summarizes the policy options discussed in this paper. It is the expectation of the Commission that the public comment process involved in evaluating the CON program will identify additional policy options and approaches that merit consideration.

Table 6
Summary of Regulatory Options

Options	Level of Government Oversight	Description	Administrative Tool
Option 1: Maintain Existing CON Regulation	No change in Government Oversight	-Market Entry Regulated by CON -Market Exit Through Notice or Exemption	Commission Decision ("Certificate of Need/Exemption/Notice)
Option 2: Expanded CON Regulation	Increase Government Oversight	-Market Entry Regulated by CON - Market Exit Through Exemption	Commission Decision (Certificate of Need/ Exemption)
Option 3: Partial Deregulation of Child and Adolescent Inpatient Psychiatric Services	A. Partial Change in Government Oversight B. Partial Change in Government Oversight	A. Market Entry by CON for C/A; Exemption for RTCs; Market Exit by Notice/Exemption B. Market Entry by Exemption for C/A; CON for RTCs; Exit by Notice/Exemption	Commission Decision (Certificate of Need/ Exemption/Notice)
Option 4: Total Deregulation of C/A Psychiatric Facilities with Monitoring by MHA/the Subcabinet/or Office For Children, Youth, and Families	Change Government Oversight	Market Entry by Exemption/Notice	Commission Decision (Exemption/Notice)
Option 5: Deregulate C/A Inpatient Psychiatric Services, Create Data Reporting Model	Change Government Oversight	No Barrier to Market Entry Or Exit	Performance Reports/ Report Cards
Option 6: Deregulate C/A Inpatient Psychiatric Inpatient Services and RTC Services from CON Review	Change Government Oversight	No Barrier to Market Entry or Exit	Remaining Agencies Exercise Oversight Authority (OHCQ, MHA, Medicaid)

APPENDICES

Appendix I
Psychiatric Utilization
Children, Adolescent & Adult
CY 1996 to CY 2000

COUNTY	*HOSPITAL PROVIDER*	*AGE*	*DISCHARGES*				
			1996	*1997*	*1998*	*1999*	*2000*
ALLEGANY	MEMORIAL CUMBERLAND	0-12 Years	2	1	0	1	3
		13-17 Years	3	1	2	0	2
		18 above	31	27	13	20	12
	SACRED HEART	0-12 Years	0	0	0	0	1
		13-17 Years	23	27	26	22	41
		18 above	536	487	598	672	657
FREDERICK	FREDERICK MEMORIAL	0-12 Years	0	1	2	1	0
		13-17 Years	3	1	4	1	1
		18 above	530	556	567	589	553
GARRETT	GARRETT COUNTY	0-12 Years	0	0	1	0	0
		13-17 Years	0	1	0	0	1
		18 above	22	14	11	22	14
WASHINGTON	WASHINGTON COUNTY	0-12 Years	1	1	0	1	2
		13-17 Years	16	19	22	9	20
		18 above	645	636	606	568	648
	WESTERN MARYLAND TOTAL		1,812	1,772	1,852	1,906	1,955
MONTGOMERY	HOLY CROSS	0-12 Years	0	0	0	1	0
		13-17 Years	6	1	5	2	1
		18 above	209	174	179	81	31
	MONTGOMERY GENERAL	0-12 Years	0	0	0	0	0
		13-17 Years	86	80	57	64	91
		18 above	873	852	912	916	991
	SHADY GROVE ADVENTIST	0-12 Years	1	0	2	2	4
		13-17 Years	2	0	2	2	2
		18 above	13	19	31	19	28
	SUBURBAN	0-12 Years	0	1	0	0	1
		13-17 Years	48	53	47	61	76
		18 above	671	567	588	706	789
	WASHINGTON ADVENTIST	0-12 Years	0	2	2	0	0
		13-17 Years	102	100	99	95	113
		18 above	1,338	1,389	1,414	1,480	1,453
	MONTCOMERY COUNTY TOTAL		3,349	3,238	3,338	3,429	3,580

COUNTY	HOSPITAL PROVIDER	AGE	DISCHARGES				
			1996	1997	1998	1999	2000
CALVERT	CALVERT MEMORIAL	0-12 Years	0	0	1	0	1
		13-17 Years	146	152	138	121	110
		18 above	340	263	324	318	355
CHARLES	CIVISTA MEDICAL	0-12 Years	0	1	0	0	0
		13-17 Years	0	0	0	0	0
		18 above	6	5	11	12	6
PRINCE	DOCTORS HOSPITAL	0-12 Years	0	1	0	0	0
GEORGE'S		13-17 Years	0	0	0	0	0
		18 above	11	9	5	12	13
	FORT WASHINGTON	0-12 Years	0	0	0	0	0
		13-17 Years	0	0	0	0	0
		18 above	0	5	0	2	5
	LAUREL REGIONAL	0-12 Years	0	0	0	0	0
		13-17 Years	8	12	8	12	8
		18 above	601	509	553	510	641
	PRINCE GEORGE'S HOSPITAL	0-12 Years	1	0	1	0	0
		13-17 Years	79	54	45	21	34
		18 above	929	754	1,000	1,040	1,244
	SOUTHERN MARYLAND	0-12 Years	0	0	0	0	2
		13-17 Years	65	73	119	104	103
		18 above	701	769	785	704	811
ST. MARY'S	ST. MARY'S	0-12 Years	1	0	0	0	0
		13-17 Years	2	4	3	5	3
		18 above	396	374	337	345	328
	SOUTHERN MARYLAND TOTAL		3,286	2,985	3,330	3,206	3,664
ANNE ARUNDEL	ANNE ARUNDEL MEDICAL	0-12 Years	0	0	0	0	0
		13-17 Years	0	1	0	2	0
		18 above	28	15	24	13	30
	NORTH ARUNDEL	0-12 Years	1	1	0	1	0
		13-17 Years	1	0	1	0	0
		18 above	634	626	571	604	689
BALTIMORE	FRANKLIN SQUARE	0-12 Years	17	136	182	173	211
COUNTY		13-17 Years	13	26	28	4	4
		18 above	750	820	904	728	954
	GBMC	0-12 Years	0	0	0	1	1
		13-17 Years	1	1	1	0	4
		18 above	35	41	39	56	82
	NORTHWEST HOSPITAL	0-12 Years	0	0	0	0	0
		13-17 Years	0	1	0	0	1
		18 above	32	31	22	25	22
	ST. JOSEPH	0-12 Years	2	9	5	6	9
		13-17 Years	8	55	69	88	86
		18 above	376	465	464	517	483

COUNTY	HOSPITAL PROVIDER	AGE	DISCHARGES				
			1996	1997	1998	1999	2000
BALTIMORE CITY	BON SECOURS	0-12 Years	0	0	0	0	0
		13-17 Years	0	0	0	0	1
		18 above	16	20	9	447	1,768
	CHILDREN'S HOSPITAL	0-12 Years	0	0	0	0	0
		13-17 Years	0	0	0	0	0
		18 above	0	0	1	0	0
	CHURCH HOSPITAL	0-12 Years	0	0	0	0	0
		13-17 Years	0	0	0	0	0
		18 above	14	13	11	8	0
	GOOD SAMARITAN	0-12 Years	0	0	0	0	0
		13-17 Years	0	0	0	0	0
		18 above	35	35	26	20	25
	HARBOR HOSPITAL	0-12 Years	0	3	0	1	0
		13-17 Years	0	0	0	0	0
		18 above	16	12	13	18	18
	JAMES L. KERNAN	0-12 Years	5	2	3	1	4
		13-17 Years	68	59	60	53	95
		18 above	0	1	0	0	0
	JOHNS HOPKINS	0-12 Years	315	231	269	237	262
		13-17 Years	250	212	193	208	233
		18 above	1,447	1,563	1,539	1,918	1,890
	JOHNS HOPKINS BAYVIEW	0-12 Years	0	0	1	0	0
		13-17 Years	25	24	24	12	20
		18 above	744	684	697	724	820
	JOHNS HOPKINS ONCOLOGY	0-12 Years	0	0	0	0	0
		13-17 Years	1	0	0	0	0
		18 above	3	0	0	2	2
	LIBERTY MEDICAL	0-12 Years	0	0	0	0	0
		13-17 Years	0	0	1	0	0
		18 above	2,270	1,995	2,143	1,039	0
	MARYLAND GENERAL	0-12 Years	0	0	0	0	0
		13-17 Years	13	0	0	1	1
		18 above	929	770	725	825	1,030
	MERCY	0-12 Years	2	2	0	0	0
		13-17 Years	39	14	9	0	0
		18 above	125	81	37	18	23
	SINAI	0-12 Years	0	0	3	1	2
		13-17 Years	4	14	27	22	17
		18 above	800	1,036	1,132	1,231	1,274
	ST. AGNES	0-12 Years	2	1	2	0	1
		13-17 Years	2	0	3	1	0
		18 above	40	24	34	35	34
	UNION MEMORIAL	0-12 Years	1	0	1	0	1
		13-17 Years	1	1	2	3	1
		18 above	903	824	879	952	1,094

COUNTY	HOSPITAL PROVIDER	AGE	DISCHARGES				
			1996	1997	1998	1999	2000
	UNIVERSITY OF MARYLAND	0-12 Years	179	260	293	340	300
		13-17 Years	12	24	20	12	14
		18 above	1,540	1,471	1,413	1,384	1,340
CARROLL	CARROLL COUNTY GENERAL	0-12 Years	0	2	18	7	6
		13-17 Years	59	73	110	101	127
		18 above	703	619	687	688	666
HARFORD	FALLSTON GENERAL	0-12 Years	0	0	0	0	0
		13-17 Years	0	0	0	0	1
		18 above	18	19	17	35	44
	HARFORD MEMORIAL	0-12 Years	0	0	0	1	0
		13-17 Years	24	25	35	28	24
		18 above	541	417	501	524	443
HOWARD	HOWARD COUNTY	0-12 Years	5	2	3	1	4
		13-17 Years	68	59	60	53	95
		18 above	542	457	413	459	466
	CENTRAL MARLAND TOTAL		17,651	17,271	17,720	17,626	18,722
CECIL	UNION HOSPITRAL	0-12 Years	0	0	0	0	0
		13-17 Years	1	0	1	0	1
		18 above	535	475	402	392	381
DORCHESTER	DORCHESTER GENERAL	0-12 Years	11	2	1	0	0
		13-17 Years	146	76	44	87	104
		18 above	310	387	327	446	526
KENT	KENT AND QUEEN ANNE'S	0-12 Years	0	0	0	0	0
		13-17 Years	0	0	1	0	0
		18 above	18	8	2	12	14
SOMERSET	EDWARD W. MC CREADY	0-12 Years	0	0	0	0	0
		13-17 Years	0	0	0	0	0
		18 above	0	14	4	5	7
TALBOT	MEMORIAL AT EASTON	0-12 Years	2	1	0	3	2
		13-17 Years	2	0	3	2	0
		18 above	171	24	15	22	28
WICOMICO	PRMC	0-12 Years	1	0	1	1	0
		13-17 Years	3	3	1	5	1
		18 above	429	408	402	476	518
WORCESTER	ATLANTIC GENERAL	0-12 Years	0	0	0	0	0
		13-17 Years	0	0	0	0	1
		18 above	4	3	5	6	5
	EASTERN SHORE TOTAL		1,633	1,401	1,209	1,457	1,588
		0-12 Years	544	657	788	778	813
		13-17 Years	1,262	1,187	1,210	1,148	1,342
		18 above	21,860	20,767	21,392	21,645	23,255
	MARYLAND TOTAL		23,666	22,611	23,390	23,571	25,410

Appendix II
Psychiatric Utilization
Children, Adolescent, and Adult
CY 1996-CY 2000

Psychiatric Discharges, 0-12 Years: Maryland, 1996-2000

Jurisdiction/ Local Health Planning Area	Hospitals	1996	1997	1998	1999	2000
Allegany	Memorial of Cumberland Hospital	2	1	-	1	3
	Sacred Heart Hospital	-	-	-	-	1
	County Total	**2**	**1**	**-**	**1**	**4**
Frederick	**Frederick Memorial Hospital**	**-**	**1**	**2**	**1**	**-**
Garrett	**Garrett County Memorial Hospital**	**-**	**-**	**1**	**-**	**-**
Washington	**Washington County Hospital**	**1**	**1**	**-**	**1**	**2**
WESTERN MARYLAND TOTAL		3	3	3	3	6
Montgomery	Holy Cross Hospital	-	-	-	1	-
	Montgomery General Hospital	-	-	-	-	-
	Shady Grove Adventist Hospital	1	-	2	2	4
	Suburban Hospital	-	1	-	-	1
	Washington Adventist Hospital	-	2	2	-	-
MONTGOMERY COUNTY TOTAL		1	3	4	3	5
Calvert	Calvert Memorial Hospital	-	-	1	-	1
Charles	Civista Medical Center*	-	1	-	-	-
Prince George's	Doctor's Community Hospital	-	-	-	-	-
	Fort Washington Medical Center*	-	-	-	-	-
	Laurel Regional Hospital	-	-	-	-	-
	Prince George's Hospital Center	1	-	1	-	-
	Southern Maryland Hospital Center	-	-	-	-	2
	Total	1	-	1	-	2
St. Mary's	St. Mary's Hospital	1	-	-	-	-

SOUTHERN MARYLAND TOTAL		2	1	2	-	3
Anne Arundel	Anne Arundel Medical Center	-	-	-	-	-
	North Arundel Hospital	1	1	-	1	-
	Total	1	1	-	1	-
Baltimore County	Northwest Hospital Center	-	-	-	-	-
	Franklin Square Hospital	17	136	182	173	211
	Greater Baltimore Medical Center	-	-	-	1	1
	St. Joseph Hospital	2	9	5	6	9
	Total	19	145	187	180	221
Baltimore City	Bon Secours Hospital	-	-	-	-	-
	Childrens Hospital	-	-	-	-	-
	Church Hospital	-	-	-	-	-
	Good Samaritan Hospital	-	-	-	-	-
	Harbor Hospital	-	3	-	1	-
	Johns Hopkins Bayview Medical Ctr.*	-	-	1	-	-
	Johns Hopkins Hospital	315	231	269	237	262
	Kernan Hospital	-	-	-	-	-
	Liberty Medical Center*	-	-	-	-	-
	Maryland General Hospital	-	-	-	-	-
	Mercy Medical Center	2	2	-	-	-
	Sinai Hospital of Baltimore	-	-	3	1	2
	St. Agnes Hospital	2	1	2	-	1
	Union Memorial Hospital	1	-	1	-	1
	University of Maryland	179	260	293	340	300
	Total	499	497	569	579	566
Carroll	Caroll County General Hospital	-	2	18	7	6
Harford	Fallston General Hospital	-	-	-	-	-
	Harford Memorial Hospital	-	-	-	-	-
	Total	-	-	-	-	-
Howard	Howard County General Hospital	5	2	3	1	4
CENTRAL MARYLAND TOTAL		524	647	777	768	797
Caroline		-	-	-	-	-
Cecil	Union Hospital of Cecil	-	-	-	-	-
Dorchester	Dorchester General Hospital	11	2	1	-	-
Kent	Kent & Queen Anne's Hospital	-	-	-	-	-

Queen Anne's		-	-	-	-	-
Somerset	E. W. McCready Memorial Hospital	-	-	-	-	-
Talbot	Memorial Hospital at Easton	2	1	-	3	2
Wicomico	Peninsula Regional Medical Center	1	-	1	1	-
Worcester	Atlantic General Hospital	-	-	-	-	-
EASTERN SHORE TOTAL		14	3	2	4	2
MARYLAND TOTAL		544	657	788	778	813

Psychiatric Discharges, 13-17 Years: Maryland, 1996-2000

Jurisdiction/ Local Health Planning Area	Hospitals	1996	1997	1998	1999	2000
Allegany	Memorial of Cumberland Hospital	3	1	2	-	2
	Sacred Heart Hospital	23	27	26	22	41
	Total	26	28	28	22	43
Frederick	Frederick Memorial Hospital	3	1	4	1	1
Garrett	Garrett County Memorial Hospital	-	1	-	-	1
Washington	Washington County Hospital	16	19	22	9	20
WESTERN MARYLAND TOTAL		45	49	54	32	65
Montgomery	Holy Cross Hospital	6	1	5	2	1
	Montgomery General Hospital	86	80	57	64	91
	Shady Grove Adventist Hospital	2	-	2	2	2
	Suburban Hospital	48	53	47	61	76
	Washington Adventist Hospital	102	100	99	95	113
MONTGOMERY COUNTY TOTAL		244	234	210	224	283
Calvert	Calvert Memorial Hospital	146	152	138	121	110
Charles	Civista Medical Center*	-	-	-	-	-
Prince George's	Doctor's Community Hospital	-	-	-	-	-
	Fort Washington Medical Center*	-	-	-	-	-
	Laurel Regional Hospital	8	12	8	12	8
	Prince George's Hospital Center	79	54	45	21	34
	Southern Maryland Hospital Center	65	73	119	104	103
	Total	152	139	172	137	145
St. Mary's	St. Mary's Hospital	2	4	3	5	3
SOUTHERN MARYLAND TOTAL		300	295	313	263	258
Anne Arundel	Anne Arundel Medical Center	-	1	-	2	-
	North Arundel Hospital	1	-	1	-	-
	Total	1	1	1	2	-

		1996	1997	1998	1999	2000
Baltimore County	Northwest Hospital Center	-	1	-	-	1
	Franklin Square Hospital	13	26	28	4	4
	Greater Baltimore Medical Center	1	1	1	-	4
	St. Joseph Hospital	8	55	69	88	86
	Total	22	83	98	92	95
Baltimore City	Bon Secours Hospital	-	-	-	-	1
	Childrens Hospital	-	-	-	-	-
	Church Hospital	-	-	-	-	-
	Good Samaritan Hospital	-	-	-	-	-
	Harbor Hospital	-	3	-	1	-
	Johns Hopkins Bayview Medical Ctr.*	25	24	24	12	20
	Johns Hopkins Hospital	250	212	193	208	233
	Johns Hopkins Oncology	1	-	-	-	-
	Kernan Hospital	-	-	-	-	-
	Liberty Medical Center*	-	-	1	-	-
	Maryland General Hospital	13	-	-	1	1
	Mercy Medical Center	39	14	9	-	-
	Sinai Hospital of Baltimore	4	14	27	22	17
	St. Agnes Hospital	2	-	3	1	-
	Union Memorial Hospital	1	1	2	3	1
	University of Maryland	12	24	20	12	14
	Total	347	292	279	260	287
Carroll	Carroll County General Hospital	59	73	110	101	127
Harford	Fallston General Hospital	-	-	-	-	1
	Harford Memorial Hospital	24	25	35	28	24
	Total	24	25	35	28	25
Howard	Howard County General Hospital	68	59	60	53	95
CENTRAL MARYLAND TOTAL		521	533	583	536	629
Caroline		-	-	-	-	-
Cecil	Union Hospital of Cecil	1	-	1	-	1
Dorchester	Dorchester General Hospital	146	76	44	87	104
Kent	Kent & Queen Anne's Hospital	-	-	1	-	-
Queen Anne's		-	-	-	-	-
Somerset	E. W. McCready Memorial Hospital	-	-	-	-	-

		1996	1997	1998	1999	2000
Talbot	Memorial Hospital at Easton	2	1	-	1	-
Wicomico	Peninsula Regional Medical Center	3	3	1	5	1
Worcester	Atlantic General Hospital	-	-	-	-	1
EASTERN SHORE TOTAL		152	80	47	93	107
MARYLAND TOTAL		1,262	1,187	1,210	1,148	1,342

Psychiatric Discharges, 18 Years and Older: Maryland, 1996-2000

Jurisdiction/ Local Health Planning Area	Hospitals	1996	1997	1998	1999	2000
Allegany	Memorial of Cumberland Hospital	31	27	13	20	12
	Sacred Heart Hospital	536	487	598	672	657
	Total	567	514	611	692	669
Frederick	Frederick Memorial Hospital	530	556	567	589	553
Garrett	Garrett County Memorial Hospital	22	14	11	22	14
Washington	Washington County Hospital	645	636	606	568	648
WESTERN MARYLAND TOTAL		1,764	1,720	1,795	1,871	1,884
Montgomery	Holy Cross Hospital	209	174	179	81	31
	Montgomery General Hospital	873	852	912	916	991
	Shady Grove Adventist Hospital	13	19	31	19	28
	Suburban Hospital	671	567	588	706	789
	Washington Adventist Hospital	1,338	1,389	1,414	1,480	1,453
MONTGOMERY COUNTY TOTAL		3,104	3,001	3,124	3,202	3,292
Calvert	Calvert Memorial Hospital	340	263	324	318	355
Charles	Civista Medical Center*	6	5	11	12	6
Prince George's	Doctor's Community Hospital	11	9	5	12	13
	Fort Washington Medical Center*	-	5	-	2	5
	Laurel Regional Hospital	601	509	553	510	641
	Prince George's Hospital Center	929	754	1,000	1,040	1,244
	Southern Maryland Hospital Center	701	769	785	704	811
	Total	2,242	2,046	2,343	2,268	2,714
St. Mary's	St. Mary's Hospital	396	374	337	345	328
SOUTHERN MARYLAND TOTAL		2,984	2,688	3,015	2,943	3,403
Anne Arundel	Anne Arundel Medical Center	28	15	24	13	30
	North Arundel Hospital	634	626	571	604	689
	Total	662	641	595	617	719

		1996	1997	1998	1999	2000
Baltimore County	Northwest Hospital Center	32	31	22	25	22
	Franklin Square Hospital	750	820	904	728	954
	Greater Baltimore Medical Center	35	41	39	56	82
	St. Joseph Hospital	376	465	464	517	483
	Total	1,193	1,357	1,429	1,326	1,541
Baltimore City	Bon Secours Hospital	16	20	9	447	1,768
	Childrens Hospital	-	-	1	-	-
	Church Hospital	14	13	11	8	-
	Good Samaritan Hospital	35	35	26	20	25
	Harbor Hospital	16	12	13	18	18
	Johns Hopkins Bayview Medical Ctr.*	744	684	697	724	820
	Johns Hopkins Hospital	1,447	1,563	1,539	1,918	1,890
	Johns Hopkins Oncology	3	-	-	2	2
	Kernan Hospital	-	1	-	-	-
	Liberty Medical Center*	2,270	1,995	2,143	1,039	-
	Maryland General Hospital	929	770	725	825	1,030
	Mercy Medical Center	125	81	37	18	23
	Sinai Hospital of Baltimore	800	1,036	1,132	1,231	1,274
	St. Agnes Hospital	40	24	34	35	34
	Union Memorial Hospital	903	824	879	952	1,094
	University of Maryland	1,540	1,471	1,413	1,384	1,340
	Total	8,882	8,529	8,659	8,621	9,318
Carroll	Caroll County General Hospital	703	619	687	688	666
Harford	Fallston General Hospital	18	19	17	35	44
	Harford Memorial Hospital	541	417	501	524	443
	Total	559	436	518	559	487
Howard	Howard County General Hospital	542	457	413	459	466
CENTRAL MARYLAND TOTAL		12,541	12,039	12,301	12,270	13,197
Caroline		-	-	-	-	-
Cecil	Union Hospital of Cecil	535	475	402	392	381
Dorchester	Dorchester General Hospital	310	387	327	446	526
Kent	Kent & Queen Anne's Hospital	18	8	2	12	13
Queen Anne's		-	-	-	-	-
Somerset	E. W. McCready Memorial Hospital	-	14	4	5	7

		1996	1997	1998	1999	2000
Talbot	Memorial Hospital at Easton	171	24	15	22	28
Wicomico	Peninsula Regional Medical Center	429	408	402	476	518
Worcester	Atlantic General Hospital	4	3	5	6	5
EASTERN SHORE TOTAL		1,467	1,319	1,157	1,359	1,478
MARYLAND TOTAL		21,860	20,767	21,392	21,645	23,255

Appendix III
Children and Adolescent Psychiatric Utilization
CY 1996

Children and Adolescent Psychiatric Utilization
CY 1996
Ages 0-11and 12-17

HOSPITAL TYPE	AGES DESC.	TOTAL CASES	PATIENT DAYS	TOTAL(*) CHARGES	AVG. ALOS	AVG.(*) CHARGE	PER(*) DIEM
CY 1996							
GENERAL HOSPITAL	0-11	527	6,639	$5,374,118	12.6	$10,198	$809
GENERAL HOSPITAL	12-17	1,414	10,613	$7,910,801	7.51	$5,595	$745
General Hospital Subtotal	0-17	1,941	17,252	$13,284,919	8.89	$6,844	$770
PRIVATE PSCYHIATRIC HOSPITALS	0-11	531	8,833	$6,346,200	16.63	$11,951	$718
PRIVATE PSYCHIATRIC	12-17	2,364	57,459	$38,278,674	24.31	$16,192	$666
Private Psychiatric Hospital Subtotal	0-17	2,895	66,292	$44,624,874	22.90	$15,414	$673
STATE PSYCHIATRIC HOSPITIAL	0-11	3	15	INA	5.00	INA	INA
STATE PSYCHIATRIC HOSPITIAL	12-17	227	6,784	INA	29.89	INA	INA
State Psychiatric Hospital Subtotal	0-17	230	6,799	INA	29.56	INA	INA
Total 0-11	0-11	1,061	15,487	$11,720,318	14.60	$11,078	$758
Total 12-17	12-17	4,005	74,856	$46,189,475	18.69	$12,226	$679
TOTAL	0-17	5,066	90,343	$57,909,793	17.83	$11,975	$693

Note: (*) Total charges, average charge, and per diem charges computed for general and private psychiatric hospitals only. INA – Information Not Available

Source: Maryland Health Care Commission, adapted from Maryland Hospital Discharge Abstract and Maryland Hospital Information System, October 2001

Appendix IV
Children and Adolescent Psychiatric Utilization
CY 1997

Children and Adolescent Psychiatric Utilization
CY 1997
Ages 0-11and 12-17

HOSPITAL TYPE	AGES DESC.	TOTAL CASES	PATIENT DAYS	TOTAL(*) CHARGES	AVG. ALOS	AVG.(*) CHARGE	PER(*) DIEM
CY 1996							
GENERAL HOSPITAL	0-11	623	6,537	$5,474,407	10.49	$8,787	$837
GENERAL HOSPITAL	12-17	1,358	9,173	$7,094,713	6.75	$5,224	$773
General Hospital Subtotal	0-17	1,981	15,710	$12,569,120	7.93	$6,345	$800
PRIVATE PSCYHIATRIC HOSPITALS	0-11	701	11,623	$7,786,010	16.58	$11,107	$670
PRIVATE PSYCHIATRIC	12-17	2,738	62,077	$33,255,557	22.67	$12,146	$536
Private Psychiatric Hospital Subtotal	0-17	3,439	73,700	$41,041,567	21.43	$11,934	$557
STATE PSYCHIATRIC HOSPITIAL	0-11	10	233	INA	23.3	INA	INA
STATE PSYCHIATRIC HOSPITIAL	12-17	320	6,404	INA	20.01	INA	INA
State Psychiatric Hospital Subtotal	0-17	330	6,637	INA	20.11	INA	INA
Total	0-11	1,334	18,393	$13,260,417	13.78	$10,015	$730
Total	12-17	4,416	77,654	$40,350,270	17.58	$9,851	$566
TOTAL	0-17	5,750	96,047	$53,610,687	16.70	$9,891	$600

Note: (*) Total charges, average charge, and per diem charges computed for general and private psychiatric hospitals only. . INA – Information Not Available

Source: Maryland Health Care Commission, adapted from Maryland Hospital Discharge Abstract and Maryland Hospital Information System, October 2001

Appendix V
Children and Adolescent Psychiatric Utilization
CY 1998

CY 1998
Ages 0-11and 12-17

HOSPITAL TYPE	AGES DESC.	TOTAL CASES	PATIENT DAYS	TOTAL(*) CHARGES	AVG. ALOS	AVG.(*) CHARGE	PER(*) DIEM
CY 1996							
GENERAL HOSPITAL	0-11	716	7,724	$6,272,930	10.79	$8,761	$812
GENERAL HOSPITAL	12-17	1,417	9,706	$7,620,204	6.85	$5,378	$785
General Hospital Subtotal	0-17	2,133	17,430	$13,893,134	8.17	$6,513	$797
PRIVATE PSCYHIATRIC HOSPITALS	0-11	707	10,601	$7,535,229	14.99	$10,658	$711
PRIVATE PSYCHIATRIC	12-17	2,519	36,994	$23,936,927	14.69	$9,503	$647
Private Psychiatric Hospital Subtotal	0-17	3,226	47,595	$31,472,156	14.75	$9,756	$661
STATE PSYCHIATRIC HOSPITIAL	0-11	8	20	INA	2.5	INA	INA
STATE PSYCHIATRIC HOSPITIAL	12-17	352	7,239	INA	20.56	INA	INA
State Psychiatric Hospital Subtotal	0-17	360	7,259	INA	20.16	INA	INA
Total	0-11	1,431	18,345	$13,808,159	12.82	$9,704	$754
Total	12-17	4,288	53,939	$31,557,131	12.58	$8,018	$676
TOTAL	0-17	5,719	72,284	$45,365,290	12.64	$8,465	$698

Note: (*) Total charges, average charge, and per diem charges computed for general and private psychiatric hospitals only. . INA – Information Not Available

Source: Maryland Health Care Commission, adapted from Maryland Hospital Discharge Abstract and Maryland Hospital Information System, October 2001

Appendix VI
Children and Adolescent Psychiatric Utilization
CY 1999

Children and Adolescent Psychiatric Utilization
CY 1999
Ages 0-11and 12-17

HOSPITAL TYPE	AGES DESC.	TOTAL CASES	PATIENT DAYS	TOTAL(*) CHARGES	AVG. ALOS	AVG.(*) CHARGE	PER(*) DIEM
CY 1996							
GENERAL HOSPITAL	0-11	725	7,331	$6,443,207	10.11	$8,887	$879
GENERAL HOSPITAL	12-17	1,333	8,986	$7,297,253	6.74	$5,474	$812
General Hospital Subtotal	0-17	2,058	16,317	$13,740,460	7.93	$6,677	$842
PRIVATE PSCYHIATRIC HOSPITALS	0-11	985	15,191	$14,463,987	15.42	$14,684	$952
PRIVATE PSYCHIATRIC	12-17	2,914	34,050	$32,661,497	11.68	$11,208	$959
Private Psychiatric Hospital Subtotal	0-17	3,899	49,241	$47,125,484	12.63	$12,087	$957
STATE PSYCHIATRIC HOSPITIAL	0-11	2	28	INA	14.0	INA	INA
STATE PSYCHIATRIC HOSPITIAL	12-17	242	6,458	INA	26.69	INA	INA
State Psychiatric Hospital Subtotal	0-17	244	6,486	INA	26.58	INA	INA
Total	0-11	1,712	22,550	$20,907,194	13.17	$12,226	$927
Total	12-17	4,489	49,494	$39,958,750	11.03	$9,409	$807
TOTAL	0-17	6,201	72,044	$60,865,944	11.62	$10,218	$845

Note: (*)Total charges, average charge, and per diem charges computed for general and private psychiatric hospitals only. INA – Information Not Available

Source: Maryland Health Care Commission, adapted from Maryland Hospital Discharge Abstract and Maryland Hospital Information System, October 2001

Appendix VII
Children and Adolescent Psychiatric Utilization
CY 2000

Children and Adolescent Psychiatric Utilization
CY 2000
Ages 0-11and 12-17

HOSPITAL TYPE	AGES DESC.	TOTAL CASES	PATIENT DAYS	TOTAL(*) CHARGES	AVG. ALOS	AVG.(*) CHARGE	PER(*) DIEM
CY 1996							
GENERAL HOSPITAL	0-11	740	6,651	$5,949,864	8.99	$8,040	$895
GENERAL HOSPITAL	12-17	1,557	9,807	$7,615,803	6.3	$4,891	$777
General Hospital Subtotal	0-17	2,297	16,458	$13,565,667	7.16	$5,906	$824
PRIVATE PSCYHIATRIC HOSPITALS	0-11	628	9,159	$6,266,436	14.58	$9,978	$684
PRIVATE PSYCHIATRIC	12-17	2,143	18,457	$13,622,673	8.61	$6,357	$738
Private Psychiatric Hospital Subtotal	0-17	2,771	27,616	$19,889,109	9.97	$7,178	$720
STATE PSYCHIATRIC HOSPITIAL	0-11	1	6	INA	6.00	INA	INA
STATE PSYCHIATRIC HOSPITIAL	12-17	176	5,438	INA	30.90	INA	INA
State Psychiatric Hospital Subtotal	0-17	177	5,444	INA	30.76	INA	INA
Total	0-11	1,369	15,816	$12,216,300	11.55	$8,930	$773
Total	12-17	3,876	33,702	$21,238,476	8.70	$5,740	$751
TOTAL	0-17	5,245	49,518	$33,454,776	9.44	$6,601	$759

Note: (*) Total charges, average charge, and per diem charges computed for general and private psychiatric hospitals only. INA – Information Not Available

Source: Maryland Health Care Commission, adapted from Maryland Hospital Discharge Abstract and Maryland Hospital Information System, October 2001

Appendix VIII
Children and Adolescent Combined Psychiatric Utilization
General Hospitals, Private and State Psychiatric Hospitals
CY 1996- CY 2000 Summary

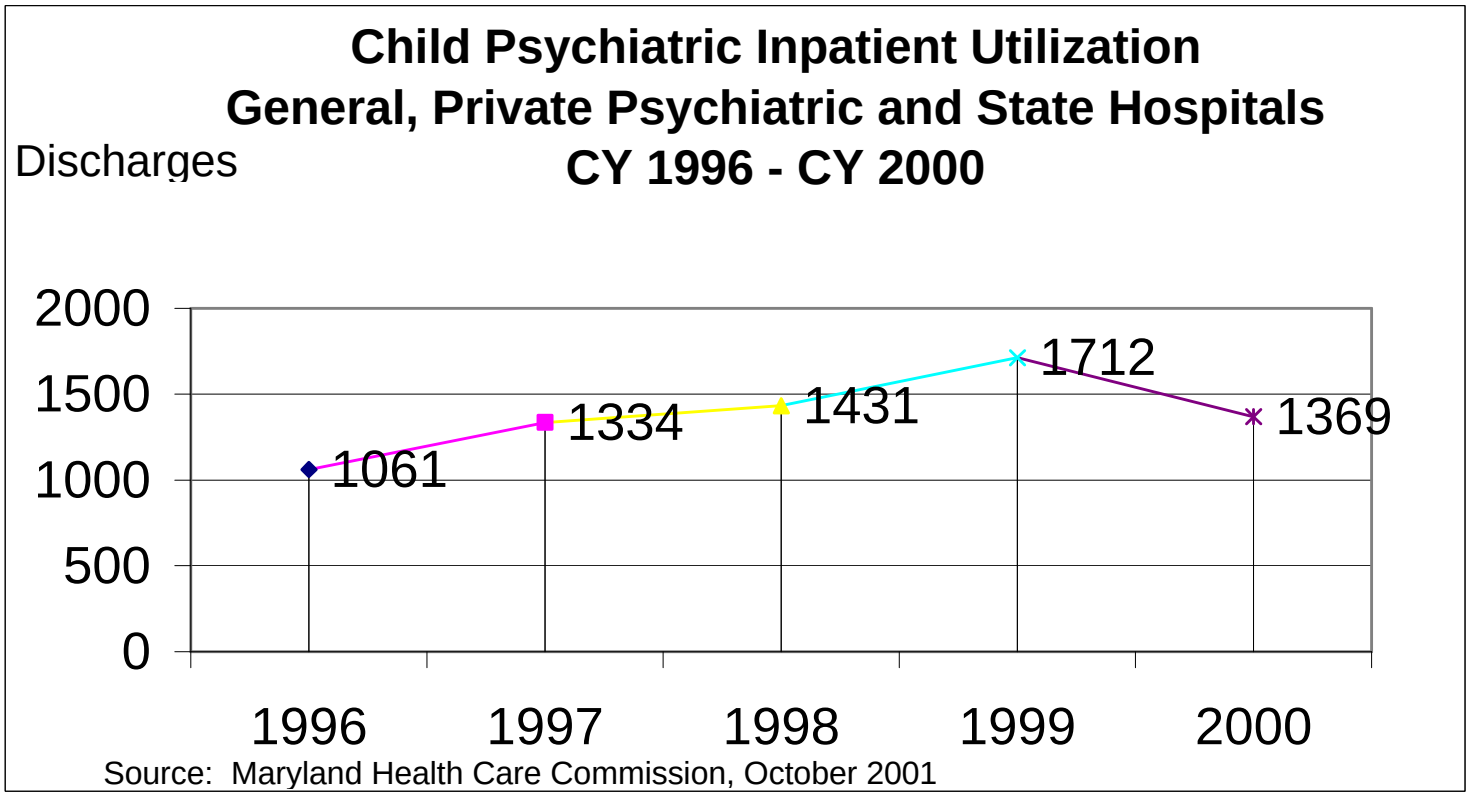
Child and Adolescent Utilization
Ages 0-11 and 12-17
CY 1996-CY 2000

HOSPITAL TYPE	AGES DESC.	TOTAL CASES	PATIENT DAYS	TOTAL(*) CHARGES	AVG. ALOS	AVG. (*) CHARGE	PER(*) DIEM
1996							
Total 0-11	0-11	1,061	15,487	$11,720,318	14.60	$11,078	$758
Total 12-17	12-17	4,005	74,856	$46,189,475	18.69	$12,226	$679
TOTAL	0-17	5,066	90,343	$57,909,793	17.83	$11,975	$693
1997							
Total 0-11	0-11	1,334	18,393	$13,260,417	13.78	$10,015	$730
Total 12-17	12-17	4,416	77,654	$40,350,270	17.58	$9,851	$566
TOTAL	0-17	5,750	96,047	$53,610,687	16.70	$9,891	$600
1998							
Total 0-11	0-11	1,431	18,345	$13,808,159	12.82	$9,704	$754
Total 12-17	12-17	4,288	53,939	$31,557,131	12.58	$8,018	$676
TOTAL	0-17	5,719	72,284	$45,365,290	12.64	$8,465	$698
1999							
Total 0-11	0-11	1712	22550	$20,907,194	13.17	$12,226	$927
Total 12-17	12-17	4489	49494	$39,958,750	11.03	$9,409	$807
TOTAL	0-17	6201	72044	$60,865,944	11.62	$10,218	$845
2000							
Total 0-11	0-11	1369	15816	$12,216,300	11.55	$8,930	$773
Total 12-17	12-17	3876	33702	$21,238,476	8.70	$5,740	$751
TOTAL	0-17	5245	49518	$33,454,776	9.44	$6,601	$759

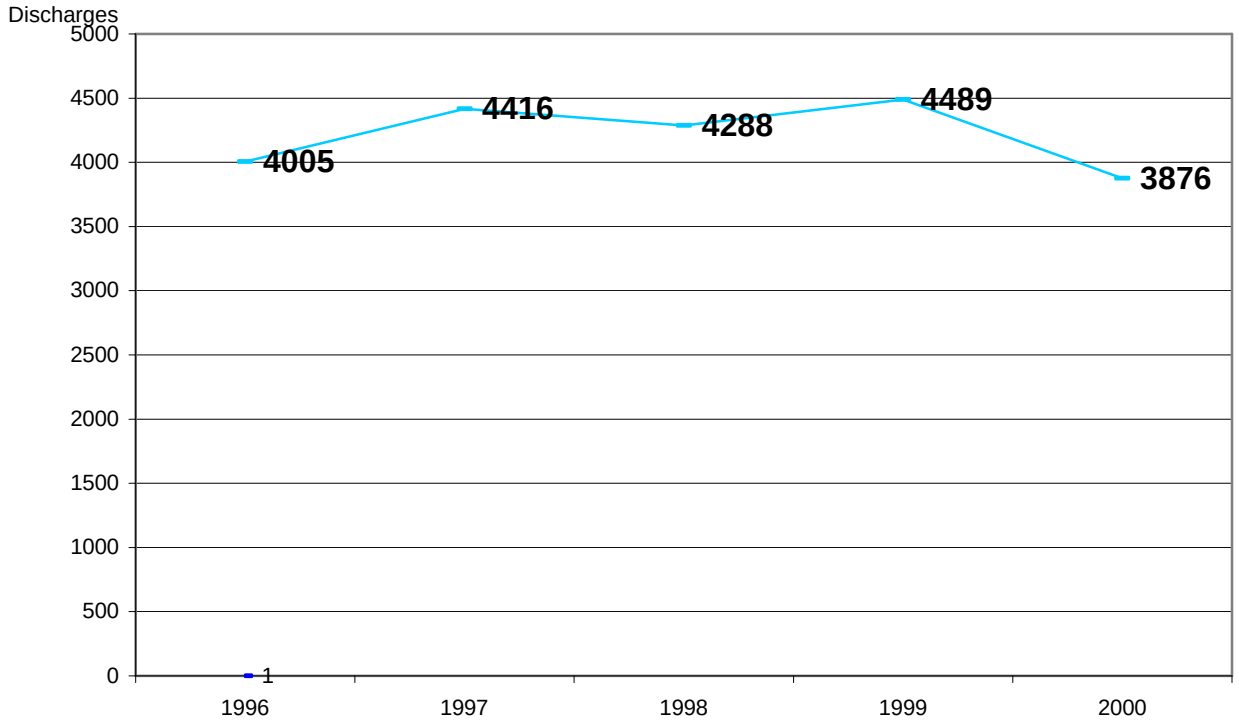
Note: (*) Total charges, average charge, and per diem charges computed for general and private psychiatric hospitals only. INA – Information Not Available

Source: Maryland Health Care Commission, adapted from Maryland Hospital Discharge Abstract and Maryland Hospital Information System, October 2001

Appendix IX
Children Psychiatric Utilization
CY 1996-CY 2000

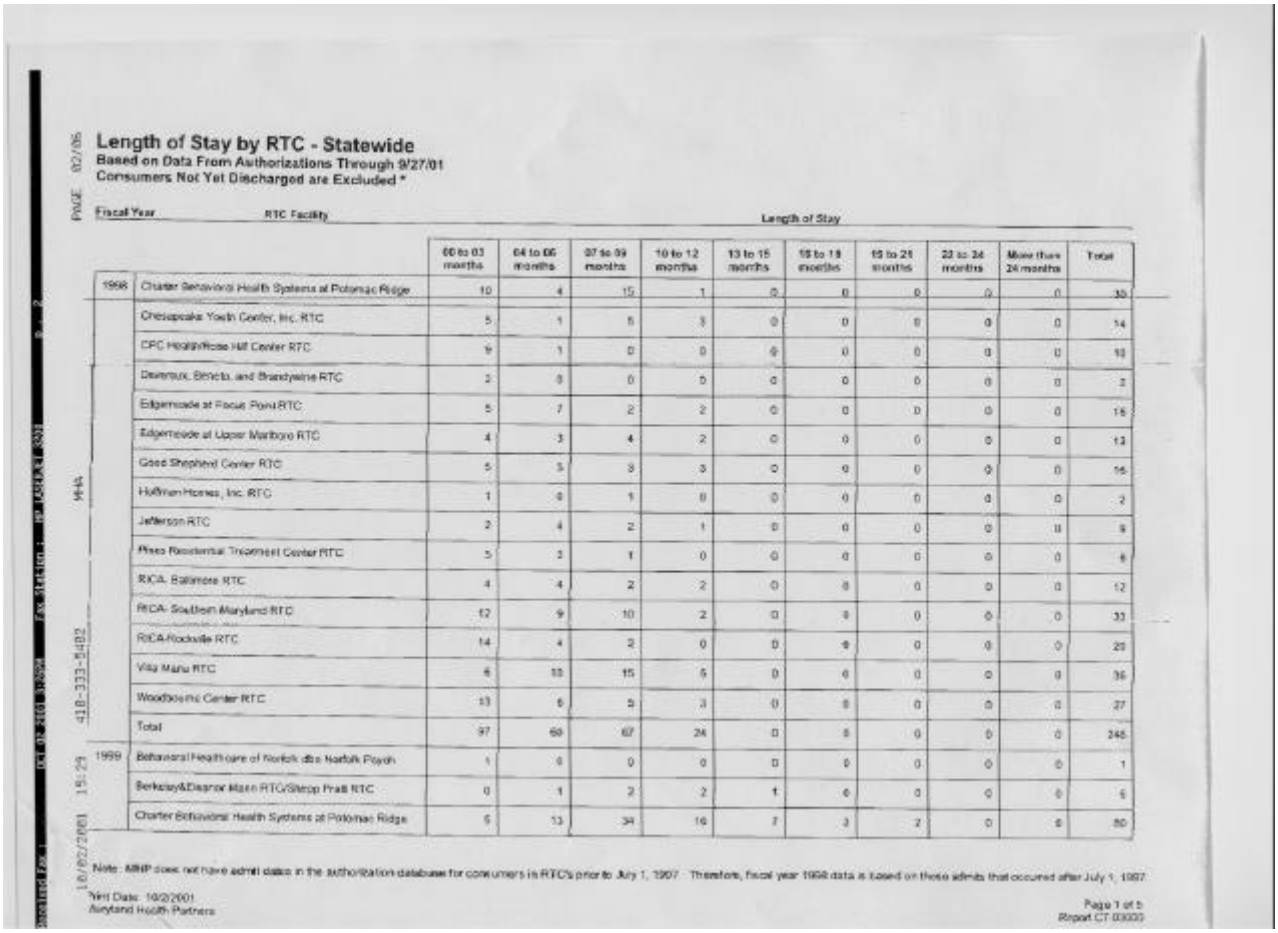


Appendix X
Total Adolescent Psychiatric Discharges
CY 1996-CY 2000



Source: Maryland Health Care Commission, October 2001

Appendix XI



Length of Stay by RTC - Statewide

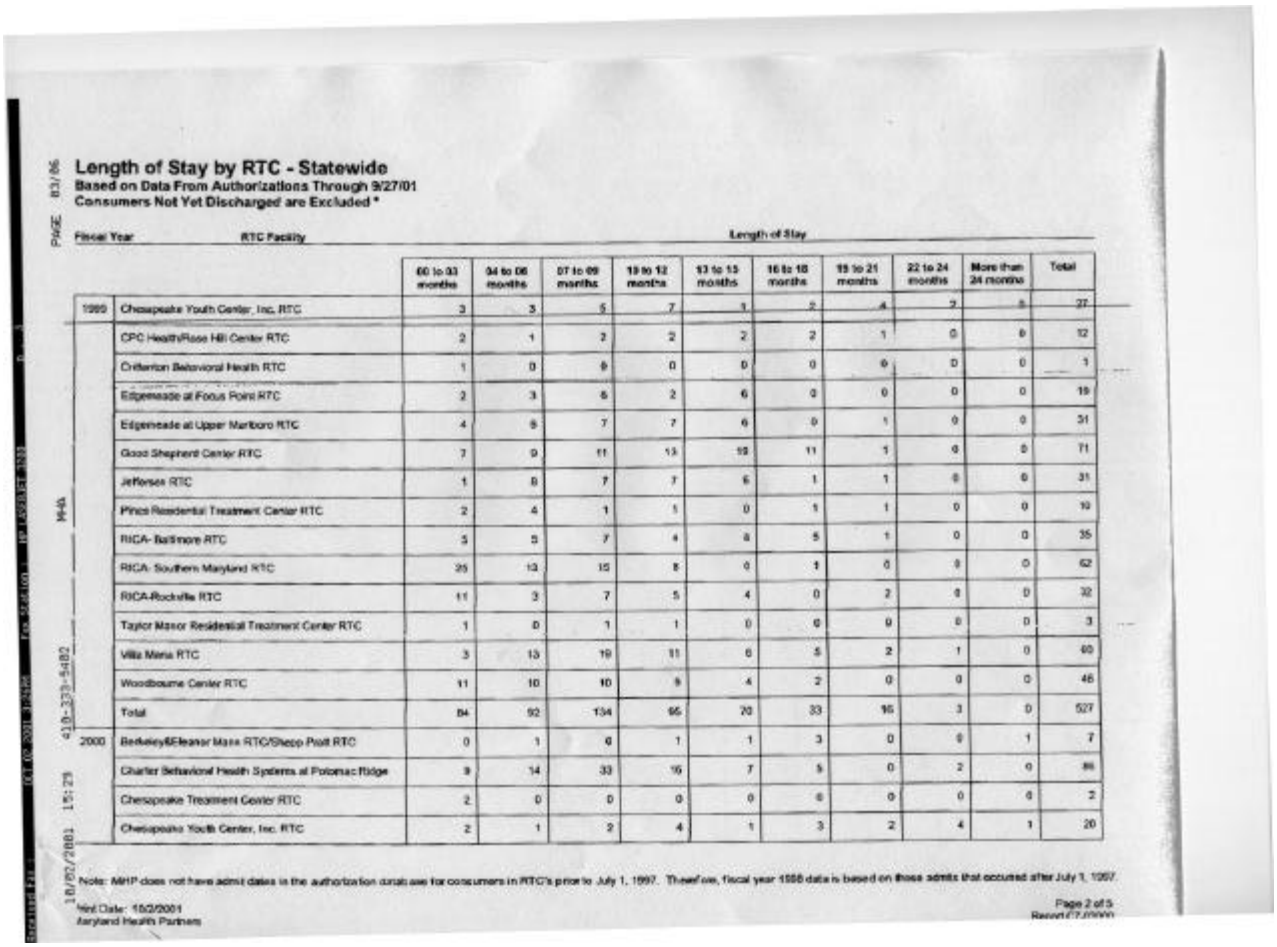
Based on Data From Authorizations Through 9/27/01
Consumers Not Yet Discharged are Excluded *

Fiscal Year	RTC Facility	Length of Stay									
		00 to 03 months	04 to 06 months	07 to 09 months	10 to 12 months	13 to 15 months	16 to 18 months	19 to 21 months	22 to 24 months	More than 24 months	Total
1998	Charter Behavioral Health Systems at Potomac Ridge	10	4	15	1	0	0	0	0	0	30
	Chesapeake Youth Center, Inc. RTC	5	1	5	3	0	0	0	0	0	14
	CPC Health/Rose Hill Center RTC	9	1	0	0	0	0	0	0	0	10
	Devereux, Benicia, and Brandywine RTC	2	0	0	0	0	0	0	0	0	2
	Edgemeade at Focus Point RTC	5	7	2	2	0	0	0	0	0	16
	Edgemeade at Upper Marlboro RTC	4	3	4	2	0	0	0	0	0	13
	Good Shepherd Center RTC	5	5	3	3	0	0	0	0	0	16
	Huffman Homes, Inc. RTC	1	0	1	0	0	0	0	0	0	2
	Jefferson RTC	2	4	2	1	0	0	0	0	0	9
	Pines Residential Treatment Center RTC	5	3	1	0	0	0	0	0	0	9
	RICA- Baltimore RTC	4	4	2	2	0	0	0	0	0	12
	RICA- Southern Maryland RTC	12	9	10	2	0	0	0	0	0	33
	RICA-Rockville RTC	14	4	2	0	0	0	0	0	0	20
	Villa Maria RTC	6	10	15	5	0	0	0	0	0	36
	Woodbourne Center RTC	13	6	5	3	0	0	0	0	0	27
	Total	97	69	67	24	0	0	0	0	0	245
1999	Behavioral Healthcare of Norfolk dba Norfolk Psych	1	0	0	0	0	0	0	0	0	1
	Berkley&Eleanor Mann RTC/Sheppard Pratt RTC	0	1	2	2	1	0	0	0	0	6
	Charter Behavioral Health Systems at Potomac Ridge	5	13	34	16	7	3	2	0	0	80

Note: MHP does not have admit dates in the authorization database for consumers in RTC's prior to July 1, 1997. Therefore, fiscal year 1998 data is based on those admits that occurred after July 1, 1997.

Print Date: 10/2/2001
Maryland Health Partners

Page 1 of 1
Report CT 03000



Length of Stay by RTC - Statewide

Based on Data From Authorizations Through 9/27/01
Consumers Not Yet Discharged are Excluded *

Fiscal Year	RTC Facility	Length of Stay									
		00 to 03 months	04 to 06 months	07 to 09 months	10 to 12 months	13 to 15 months	16 to 18 months	19 to 21 months	22 to 24 months	More than 24 months	Total
1999	Chesapeake Youth Center, Inc. RTC	3	3	5	7	1	2	4	2	0	27
	CPC Health/Rose Hill Center RTC	2	1	2	2	2	2	1	0	0	12
	Crittenton Behavioral Health RTC	1	0	0	0	0	0	0	0	0	1
	Edgemeade at Focus Point RTC	2	3	6	2	6	0	0	0	0	19
	Edgemeade at Upper Marlboro RTC	4	6	7	7	6	0	1	0	0	31
	Good Shepherd Center RTC	7	9	11	13	10	11	1	0	0	71
	Jefferson RTC	1	8	7	7	6	1	1	0	0	31
	Pines Residential Treatment Center RTC	2	4	1	1	0	1	1	0	0	10
	RICA- Baltimore RTC	5	5	7	4	8	5	1	0	0	35
	RICA- Southern Maryland RTC	25	13	15	8	0	1	0	0	0	62
	RICA-Rockville RTC	11	3	7	5	4	0	2	0	0	32
	Taylor Manor Residential Treatment Center RTC	1	0	1	1	0	0	0	0	0	3
	Villa Maria RTC	3	13	19	11	6	5	2	1	0	60
	Woodbourne Center RTC	11	10	10	9	4	2	0	0	0	46
	Total	84	92	134	85	70	33	16	3	0	527
2000	Berkley/Eleanor Mann RTC/Sheppard Pratt RTC	0	1	0	1	1	3	0	0	1	7
	Charter Behavioral Health Systems at Potomac Ridge	9	14	33	15	7	5	0	2	0	85
	Chesapeake Treatment Center RTC	2	0	0	0	0	0	0	0	0	2
	Chesapeake Youth Center, Inc. RTC	2	1	2	4	1	3	2	4	1	20

Note: MHP does not have admit dates in the authorization database for consumers in RTC's prior to July 1, 1997. Therefore, fiscal year 1998 data is based on those admits that occurred after July 1, 1997.

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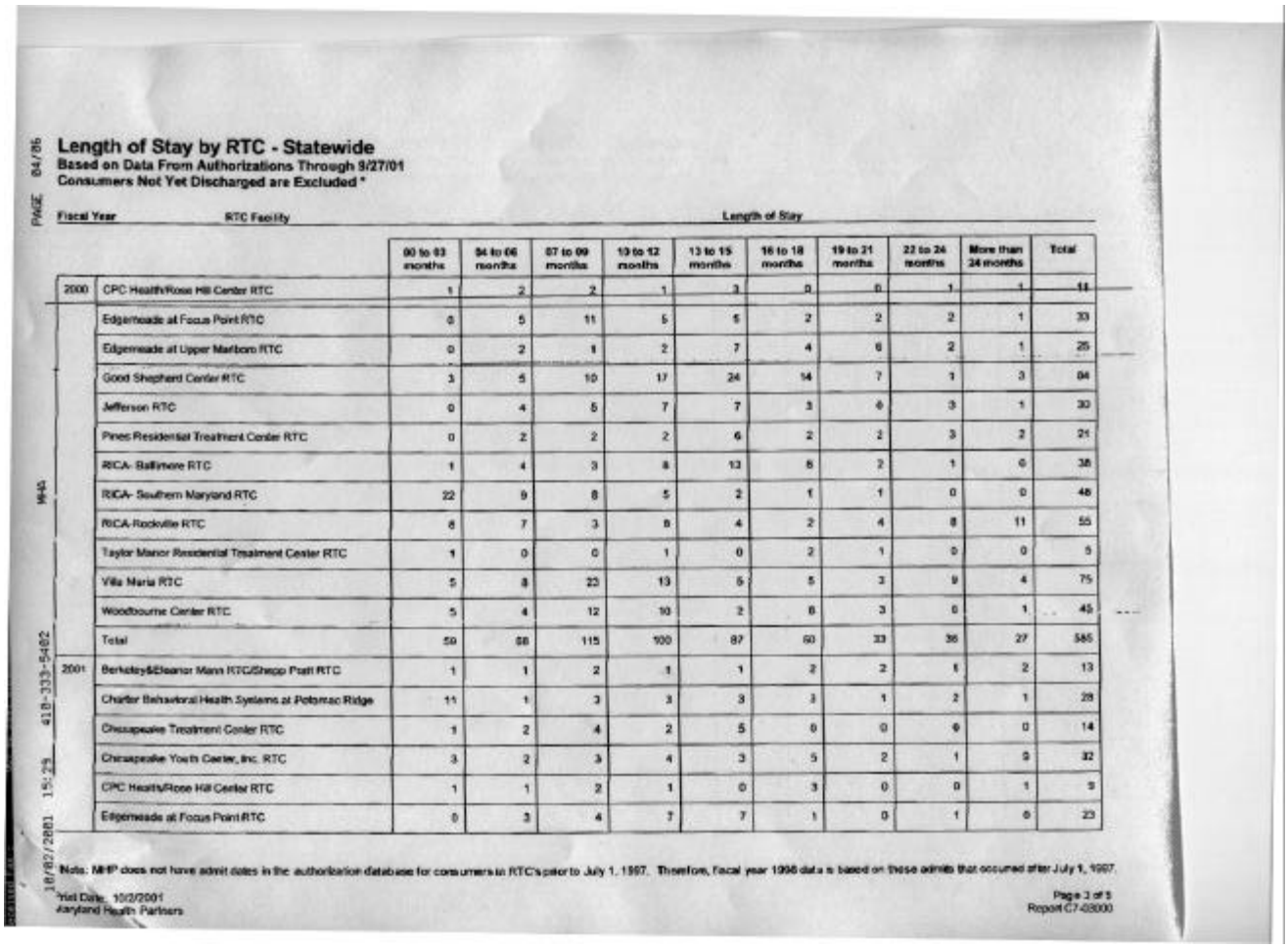

Length of Stay by RTC - Statewide

Based on Data From Authorizations Through 9/27/01
Consumers Not Yet Discharged are Excluded *

Fiscal Year	RTC Facility	Length of Stay									
		00 to 03 months	04 to 06 months	07 to 09 months	10 to 12 months	13 to 15 months	16 to 18 months	19 to 21 months	22 to 24 months	More than 24 months	Total
2000	CPC Health/Rose Hill Center RTC	1	2	2	1	3	0	0	1	1	11
	Edgemeade at Focus Point RTC	0	5	11	5	5	2	2	2	1	33
	Edgemeade at Upper Marlboro RTC	0	2	1	2	7	4	6	2	1	25
	Good Shepherd Center RTC	3	5	10	17	24	14	7	1	3	84
	Jefferson RTC	0	4	5	7	7	3	6	3	1	36
	Pines Residential Treatment Center RTC	0	2	2	2	6	2	2	3	2	21
	RICA- Baltimore RTC	1	4	3	8	13	5	2	1	0	38
	RICA- Southern Maryland RTC	22	9	8	5	2	1	1	0	0	48
	RICA-Rockville RTC	6	7	3	8	4	2	4	8	11	55
	Taylor Manor Residential Treatment Center RTC	1	0	0	1	0	2	1	0	0	5
	Villa Maria RTC	5	8	23	13	5	5	3	9	4	75
	Woodbourne Center RTC	5	4	12	10	2	8	3	0	1	45
	Total	59	68	115	100	87	60	33	36	27	585
2001	Berkeley&Eleanor Mann RTC/Shepp Pratt RTC	1	1	2	1	1	2	2	1	2	13
	Charter Behavioral Health Systems at Potomac Ridge	11	1	3	3	3	3	1	2	1	28
	Chesapeake Treatment Center RTC	1	2	4	2	5	0	0	0	0	14
	Chesapeake Youth Center, Inc. RTC	3	2	3	4	3	5	2	1	9	32
	CPC Health/Rose Hill Center RTC	1	1	2	1	0	3	0	0	1	9
	Edgemeade at Focus Point RTC	0	3	4	7	7	1	0	1	0	23

Note: MHP does not have admit dates in the authorization database for consumers in RTC's prior to July 1, 1997. Therefore, fiscal year 1998 data is based on those admits that occurred after July 1, 1997.

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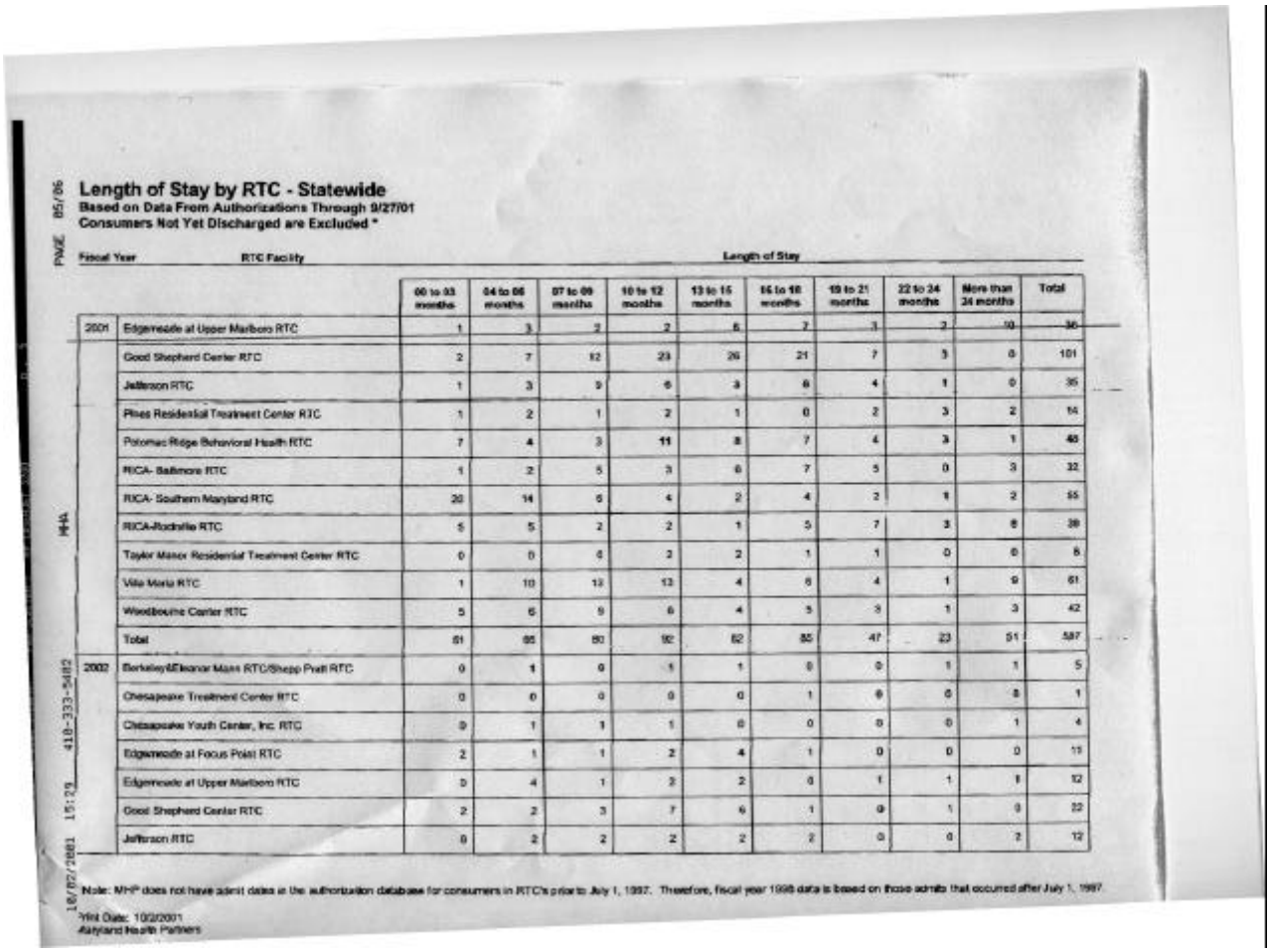
Page 3 of 5
Report C7-03000



PWE 05/06

Length of Stay by RTC - Statewide

Based on Data From Authorizations Through 9/27/01
Consumers Not Yet Discharged are Excluded *

Fiscal Year	RTC Facility	Length of Stay									
		00 to 03 months	04 to 06 months	07 to 09 months	10 to 12 months	13 to 15 months	16 to 18 months	19 to 21 months	22 to 24 months	More than 24 months	Total
2001	Edgemeade at Upper Marlboro RTC	1	3	2	2	5	7	3	2	10	35
	Good Shepherd Center RTC	2	7	12	23	26	21	7	3	0	101
	Jefferson RTC	1	3	5	6	3	8	4	1	0	35
	Pines Residential Treatment Center RTC	1	2	1	2	1	0	2	3	2	14
	Potomac Ridge Behavioral Health RTC	7	4	3	11	8	7	4	3	1	48
	RICA- Baltimore RTC	1	2	5	3	6	7	5	0	3	32
	RICA- Southern Maryland RTC	20	14	6	4	2	4	2	1	2	55
	RICA-Rockville RTC	5	5	2	2	1	5	7	3	8	38
	Taylor Manor Residential Treatment Center RTC	0	0	0	2	2	1	1	0	0	6
	Villa Maria RTC	1	10	13	13	4	6	4	1	9	61
	Woodbourne Center RTC	5	6	9	6	4	5	3	1	3	42
	Total	51	65	60	92	62	65	47	23	51	587
2002	Berkeley/Eleanor Mann RTC/Shepp Pratt RTC	0	1	0	1	1	0	0	1	1	5
	Chesapeake Treatment Center RTC	0	0	0	0	0	1	0	0	0	1
	Chesapeake Youth Center, Inc. RTC	0	1	1	1	0	0	0	0	1	4
	Edgemeade at Focus Point RTC	2	1	1	2	4	1	0	0	0	11
	Edgemeade at Upper Marlboro RTC	0	4	1	3	2	0	1	1	1	12
	Good Shepherd Center RTC	2	2	3	7	6	1	0	1	0	22
	Jefferson RTC	0	2	2	2	2	2	0	0	2	12

Note: MHP does not have admit dates in the authorization database for consumers in RTC's prior to July 1, 1997. Therefore, fiscal year 1998 data is based on those admits that occurred after July 1, 1997.

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MHA 410-333-5482 10/02/2001 15:29

Length of Stay by RTC - Statewide

Based on Data From Authorizations Through 9/27/01
Consumers Not Yet Discharged are Excluded *

Fiscal Year	RTC Facility	Length of Stay									
		00 to 03 months	04 to 06 months	07 to 09 months	10 to 12 months	13 to 15 months	16 to 18 months	19 to 21 months	22 to 24 months	More than 24 months	Total
2002	Pines Residential Treatment Center RTC	0	0	0	2	0	1	0	0	0	3
	Potomac Ridge Behavioral Health RTC	1	3	0	2	2	1	3	0	1	13
	RICA- Baltimore RTC	2	1	3	1	2	5	2	1	2	19
	RICA- Southern Maryland RTC	7	2	1	3	0	0	0	0	0	13
	RICA-Rockville RTC	3	4	3	7	8	6	4	1	6	42
	Taylor Manor Residential Treatment Center RTC	0	0	1	2	0	0	0	0	0	3
	Villa Maria RTC	2	3	1	4	6	3	0	3	2	24
	Woodbourne Center RTC	4	3	0	6	2	0	3	2	1	21
		23	27	17	42	35	21	13	10	17	205
All Fiscal YearsTotal		334	313	413	353	274	199	109	72	95	2,152

MHA 410-333-5402 10/02/2001 15:29

Note: MHP does not have admit dates in the authorization database for consumers in RTC's prior to July 1, 1997. Therefore, fiscal year 1998 data is based on those admits that occurred after July 1, 1997.

Print Date: 10/2/2001
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MAP APPENDICES A-B

A. **Child and Adolescent Psychiatric Hospital Facilities in Maryland October 2001**

B. **Maryland Residential Treatment Centers, October 2001**